# WORK GROUP FINAL RECOMMENDATIONS

December 17, 2014

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*Washington State Common Measure Set for Health Care Quality and Cost*

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## INTRODUCTION AND BACKGROUND

In 2014, the Washington State Legislature passed ESHB 2572, a law relating to improving the effectiveness of health care purchasing and transforming the health care delivery system. A portion of this legislation (Section 6) relates to the development of a statewide core measure set for health care quality and cost. In response, Governor Inslee appointed a 34-member Performance Measurement Coordinating Committee (PMCC) that was charged with recommending standard statewide measures of health performance by January 1, 2015. It is intended that use of these measures will enable a common way of tracking health and health care performance as well as inform public and private health care purchasers. Use of the measures is expected to start with the State as "first mover;" the State's Health Innovation Plan calls for eventual alignment of measurement across public and private payers, using the core measure set as the basic set to which other measures may be added.

At the start, the PMCC formulated three technical work groups, including prevention, acute care and chronic illness. Each work group was charged with reviewing specific measures within their domain against criteria selected and prioritized by the PMCC during its initial meeting, and then formulating a recommended set of measures (bringing together the three domains) that:

- Is of manageable size (target ~ 45 measures);
- Is based on *readily available* health care insurance claims, survey and/or clinical data to enable timely implementation;
- Gives preference to nationally vetted measures, particularly measures endorsed by the National Quality Forum (NQF), for which there are readily available measure definitions and specifications;
- Reflects areas of health and health care thought to have a significant impact on health care outcomes and/or reducing costs over time; and,
- Is aligned to the extent possible with the Governor's performance management system measures and common measure requirements specific to the Medicaid program.

The three work groups consisted of a total of 35 individuals (see Appendix C for a list of work group members). All three work groups generally followed the same process for reviewing and selecting measures. Although it was a somewhat fluid process, it included the following steps: (1) review aligned measures already commonly used in Washington State and/or in national measure sets; (2) agree upon key topic areas to organize the remaining measures for review; (3) go through the entire list by topic area and each measure within that topic area and discuss whether to include the measure (yes/maybe/no); (4) take second pass through the yes/maybe list; (5) review additional measures recommended by group members and non-group members and determine whether to consider; and (6) review entire list and narrow recommended measures to targeted number of measures. At the conclusion of the public comment period, all three work groups had the opportunity to review the feedback and consider whether to modify their recommendations prior to finalizing them for the Performance Measures Coordinating Committee.

Topic areas identified by the work groups at the outset of the process offered a useful organizing mechanism to ensure review of potential measures in all key areas. Please note that some topic areas span two work groups. In total, the work groups reviewed approximately 350 potential measures. We were unable to recommend one or more measures for every topic listed below.

| Prevention | Chronic Illness | Acute Care |
|---|---|---|
| 1. Adult Screenings | 1. Asthma | 1. Avoidance of Overuse/Potentially Avoidable Care |
| 2. Behavioral Health/Depression | 2. Care Coordination | 2. Behavioral Health |
| 3. Childhood: Early and Adolescents | 3. Depression | 3. Cardiac Care |
| 4. Immunizations | 4. Diabetes | 4. Cost and Utilization |
| 5. Nutrition/Physical Activity/Obesity | 5. Drug and Alcohol Use | 5. Readmissions/Care Transitions |
| 6. Obstetrics | 6. Functional Status | 6. Obstetrics |
| 7. Oral Health | 7. Hypertension and Cardiovascular Disease | 7. Patient Experience: Inpatient |
| 8. Safety/Accident Prevention | 8. Medications | 8. Patient Safety |
| 9. Tobacco Cessation | 9. Patient Experience: Outpatient | 9. Pediatrics |
| | | 10. Stroke |

The report that follows focuses on **53** measures that are being recommended for inclusion in Washington State's "starter set" of measures. The term "starter set" indicates that this will be Washington's first iteration of a statewide core measure set and that it is expected that the measure set will evolve over time. The report delineates a number of elements for each recommended measure, including: (1) summary of the measure; (2) measure steward; (3) NQF reference number if the measure is NQF-endorsed; (4) type of data required to complete measurement; (5) data source in Washington (i.e., which organization will responsibility for producing and/or compiling results); (6) recommended unit(s) of analysis; and (7) whether or not to stratify results and, if so, how.

On page 6, a diagram offers a visual depiction of the contextual framework for this work. The 53 measures recommended for inclusion in Washington State's "starter set" are divided into three categories: Population, Clinical and Health Care Costs.

1. **POPULATION Measures**
   - Population measures focus on prevalence.
   - Measure results can *only* be produced for the state, counties and Accountable Communities of Health (groupings of counties). Measure results will not be available at the health plan, medical group or hospital levels.
   - Improving results* generally requires interventions in and across community settings, with action taken by Accountable Communities of Health, public health, schools, state and local agencies, state and local policy-makers and others.
2. **CLINICAL Measures**
   - Clinical measures focus on clinical processes or outcomes.
   - Many of the recommended measures focus on process (rather than outcomes) because we have not yet developed a robust infrastructure in Washington state to enable cost-effective aggregation of clinical data from medical records to support broad measurement and public reporting.
   - Measure results can be produced for health plans, medical groups and/or hospitals, depending on the recommended measure. Health plan and medical group measures are further categorized by children and adults. For many of these measures (but not all), results may also be available by state and/or county.
   - Improving results* generally requires interventions in and across clinical settings, with action taken by integrated delivery systems, medical groups and/or hospitals.

***Note***: Concerted efforts to align improvement strategies between and among *community and clinical settings* will have a stronger impact on consumer/patient engagement and accelerate improvement.

3. **HEALTH CARE COST Measures**
   - There are currently very few, if any, health care cost measures in wide use around the country. There is not a robust pool of measures with detailed measure specifications and implementation experience upon which to draw.
   - Washington State does not currently have the infrastructure in place to readily measure health care costs using multi-payer data. Today, all health care cost data is held individually by payers, third party administrators and some self-funded purchasers. Legislation was passed in Washington in 2014 to establish a state-mandated all-payer claims database (APCD). However, the legislation only mandates the participation of insurers that support the state's PEB and Medicaid populations. Further restrictions within the legislation make it impossible to generate valid and reliable reports. Therefore, until such time that the state's APCD legislation is modified to include ALL payers and lift reporting restrictions, we are hampered in terms of "readily available data" to support health care cost measures in the "starter set."
   - Given the lack of access to robust, multi-payer cost data, the recommended measures in this report are considered a starting point. Once the infrastructure necessary to support more detailed and actionable measurement and reporting using multi-payer data is built, different measures should be considered. Suggestions for *future* health care cost measures are offered on page 13 of this report.

## LOOKING TO THE FUTURE

- It is understood that this is a "starter set" of measures rather than an all-encompassing set of measures that would almost certainly overwhelm early efforts to launch measurement and standardize measures across state and private payers. The state's core measure set will change over time as priorities, evidence, measurement capability and nationally vetted measures evolve. [Note: It is also understood that this starter set of measures is not intended to define the entire universe of health care measurement and reporting in Washington. There are many important measurement activities currently underway within public health, the health care delivery system, and research/academia that will continue and add to our collective knowledge of performance and opportunities for improvement.]
- Throughout the work groups' processes, they continually identified general topics (and even specific measures sometimes) that were felt to be very important but for which we do not have either (1) readily available data to support measurement and public reporting, and/or (2) nationally vetted measures with detailed measure specifications. The current lack of a robust infrastructure in Washington state to enable cost-effective aggregation of *clinical* data from medical records for measurement and public reporting was a particularly rate-limiting element of the work.
- Starting on page 11, the report includes a prioritized list of topic areas that were identified during the work groups' processes; these topics hold interest for inclusion in a FUTURE evolution of the measure set. More explanation is included regarding these topic areas and how they were prioritized.

## ACKNOWLEDGEMENTS

- First and foremost, the 35 members of the work groups should be recognized. Each of the three work groups met eight times between early July and early December to complete their work, devoting over 800 person hours to the task. Their commitment to the process and their expertise were essential to completing the work. Second, this work could not have been completed, particularly in this tight timeframe, without the support and expertise of three individuals from Bailit Health Purchasing: Michael Bailit, Beth Waldman and Kate Bazinsky. We are grateful that they allowed us to utilize a test version of their Buying Value Measure Selection Tool which has only recently been released for more broad-scale use. Our ability to work with the Bailit Health Purchasing team was made possible by the generous support of the Aligning Forces for Quality Program of the Robert Wood Johnson Foundation. The Washington Health Alliance provided support and facilitation for the three work groups via a contract with the Washington State Health Care Authority. Susie Dade provided lead staff support for all three work groups.

## For more information about this process or the recommendations in this report, please contact:

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## RESULTS OF THE PUBLIC COMMENT PERIOD: NOVEMBER 2014

During November 2014, the draft measures originally recommended for inclusion in Washington State's "starter set" were released for public comment. The Washington State Health Care Authority sent notice to over 900 individuals inviting participation in a web-based survey designed to gather both quantitative and narrative comment.

Sixty-seven individuals responded to the survey, with a total of 47 complete surveys (i.e., all questions answered). All survey responses were shared with the three technical workgroups to enhance their deliberations in finalizing the recommended measure set. Below is a summary of the quantitative data collected via survey. In Appendix E you will find the verbatim comments, organized by theme, and in Appendix F, you'll find a summary of the workgroups' deliberations and actions in response to comments/suggestions made via the public comment period.

**To summarize, the three workgroups took action to maintain the originally recommended measures in the "starter set" with two exceptions. Action was taken to (1) remove the measure on HIV screening and (2) add a measure on Exclusive Breast Milk Feeding. The recommended measure set continues to have 53 measures in it.**

### SURVEY RESULTS

| **Do you understand the purpose of the statewide core measures set? (N = 67)** | | |
|---|---|---|
| *Yes* | *Somewhat* | *No* |
| 70% | 24% | 6% |



| **Do you understand the purpose of the statewide core measures set? (N = 67)** | | |
|---|---|---|
| *Yes* | *Somewhat* | *No* |
| 70% | 24% | 6% |



| **Have you had the opportunity to review the final draft list of proposed measures posted on the Healthier WA Performance Measures web page? (N = 66)** | | |
|---|---|---|
| *Yes* | *Somewhat* | *No* |
| 82% | 14% | 4% |

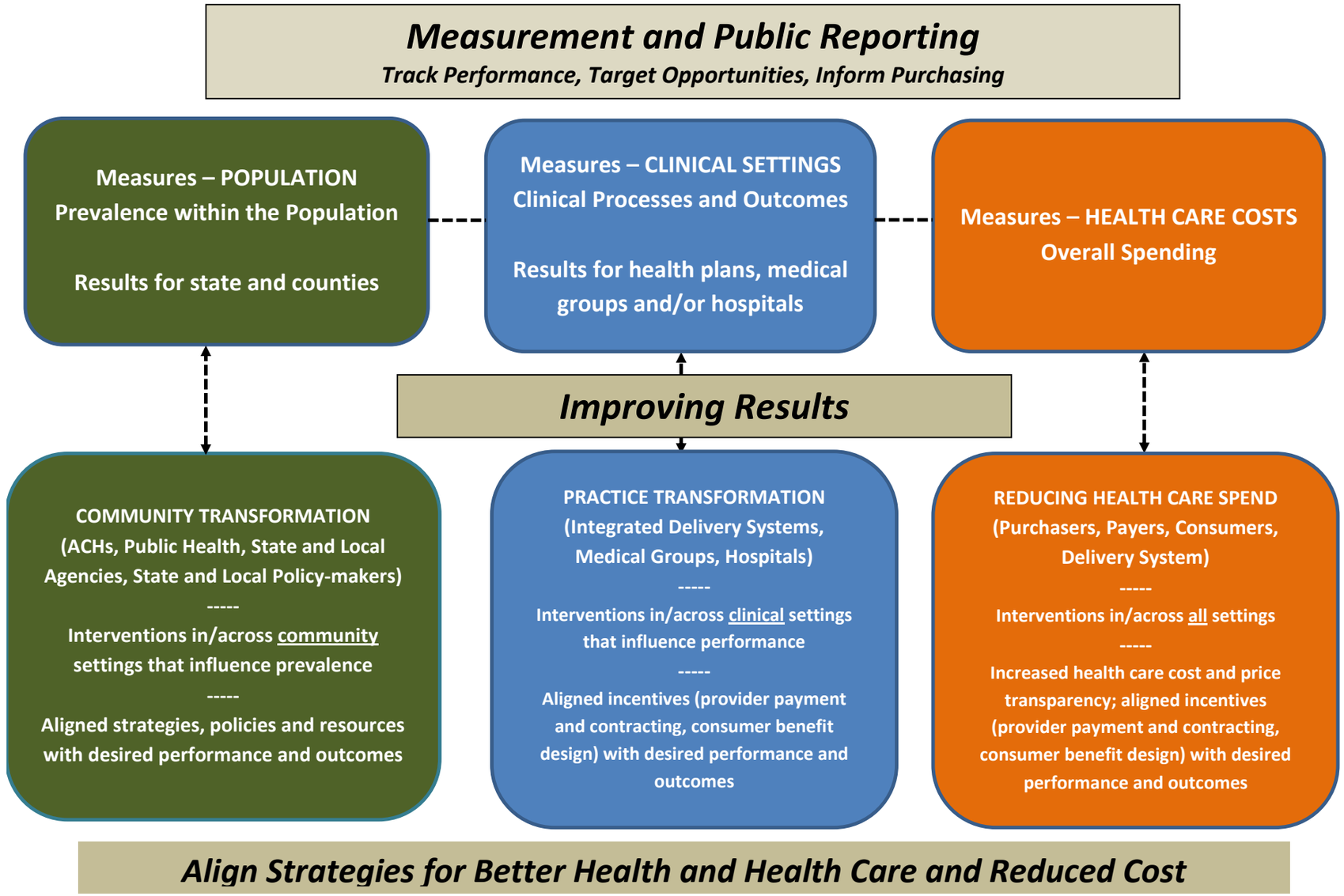
| **Do you think that the process to select the draft core measures was communicated in a clear and timely manner? (N = 51)** | | |
|---|---|---|
| *Yes* | *Somewhat* | *No* |
| 57% | 37% | 6% |

| **Recognizing that this is considered a "starter set" that will evolve over time, do you agree with the recommended measures included in the proposed measure set? (N = 56)** | | |
|---|---|---|
| *Yes* | *Somewhat* | *No* |
| 32% | 61% | 7% |

**Do you think there are measures/topics that SHOULD NOT be included, but currently are? (N = 53)**
*Yes* = 40% *No* = 60%

**Do you think there are measures/topics that SHOULD be included, but currently are not? (N = 49)**
*Yes* = 57% *No* = 43%

# *STATEWIDE COMMON MEASURES – "STARTER SET"*



# Overview of Recommended Measures:

**RECOMMENDED MEASURES – POPULATION**
**Prevalence within the Population**
**Results for State, Counties/Accountable Communities of Health**
*(Note: Many, but not all, measures shown to the right will also have results at the state and/or county levels).*

1. **Immunization: Influenza**
2. **Unintended Pregnancies**
3. **Tobacco: % of Adults who Smoke Cigarettes**
4. **Behavioral Health: % of Adults Reporting 14 or more Days of Poor Mental Health**
5. **Ambulatory Care Sensitive Hospitalizations for COPD**

**RECOMMENDED MEASURES – HEALTH CARE COSTS**

51. **Annual State-purchased Health Care Spending Relative to State's GDP**
52. **Medicaid Spending per Enrollee**
53. **Public Employee and Dependent Spending per Enrollee (Include Public Schools)**

**RECOMMENDED MEASURES – CLINICAL SETTINGS**
**Clinical Processes or Outcomes**
**Results for Health Plans, Medical Groups and/or Hospitals**

| Health Plan (Only) | Primary Care Medical Groups (4 or more Providers) | Hospitals |
|---|---|---|
| **Children/Adolescents**<br>6. Access to Primary Care<br>7. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life<br>8. Youth Obesity: BMI Assessment/Counseling<br>9. Oral Health: Primary Caries Prevention/ Intervention | **Children/Adolescents**<br>19. Immunization: Childhood Status<br>20. Immunizations: Adolescent Status<br>21. Immunizations: HPV Vaccine for Adolescents<br>22. Appropriate Testing for Children with Pharyngitis | 40. Patient Experience: Communication about Medications and Discharge Instructions<br>41. 30-day All Cause Readmissions*<br>42. Potentially Avoidable ED Visits*<br>43. Patients w/ 5 of More ED Visits *without* Care Guidelines<br>44. Exclusive Breast Milk Feeding<br>45. C-Section NTSV<br>46. 30-day Mortality: Heart Attack<br>47. Catheter-associated Urinary Tract Infection<br>48. Stroke: Thrombolytic Therapy<br>49. Falls with Injury per Patient Day<br>50. Complications/Patient Safety Composite (11 components)<br><br>**Results also available for medical groups.* |
| **Adults**<br>10. Access to Primary Care<br>11. Adult Obesity: BMI Assessment/Counseling<br>12. Medical Assistance with Smoking and Tobacco Use Cessation<br>13. Colorectal Cancer Screening*<br>14. Diabetes Care: Blood Pressure Control<br>15. Diabetes Care: HbA1c Poor Control<br>16. Hypertension: Blood Pressure Control<br>17. Follow-up After Hospitalization for Mental Illness @ 7 days, 30 days<br>18. 30-day Psychiatric Inpatient Readmission<br><br>**Results available for medical groups starting in 2016.* | **Adults**<br>23. Patient Experience: Provider Communication<br>24. Screening: Cervical Cancer<br>25. Screening: Chlamydia<br>26. Screening: Breast Cancer<br>27. Immunizations: Pneumonia (Older Adults)<br>28. Avoidance of Antibiotics for Acute Bronchitis<br>29. Avoidance of Imaging for Low Back Pain<br>30. Asthma: Use of Appropriate Medications<br>31. Cardiovascular Disease: Use of Statins<br>32. COPD: Use of Spirometry in Diagnosis<br>33. Diabetes: HbA1c Testing<br>34. Diabetes: Eye Exams<br>35. Diabetes: Screening for Nephropathy<br>36. Depression: Medication Management<br>37. Medication Adherence: Proportion of Days Covered<br>38. Medication Safety: Annual Monitoring for Patients on Persistent Medications<br>39. Medications: Rate of Generic Prescribing | |

## RECOMMENDATIONS: "STARTER SET" OF MEASURES *(Order of measures matches the order of measures included in the diagram on page 6 of this report.)*

| | Measure[1] | WG[2] | Steward[3] | NQF #[4] | Type of Data[5] | Data Source[6] | Confidence Level[7] | Recommended Unit(s) of Analysis[8] [9] | | | | | Stratify[10] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | State-wide | County or ACH | Health Plan | Medical Group[11] | Hospital | |
| 1. | Immunization: Influenza | Prevention | AMA-PCPI | 0041 | WA IIS | WA IIS | Medium | X | X | | | | |
| 2. | Unintended Pregnancies | Prevention | PRAMS | NA | Survey | CDC (PRAMS) | High | X | X | | | | |
| 3. | Percentage of adults who smoke cigarettes | Prevention | BRFSS | NA | Survey | WA State Department of Health | High | X | X | | | | |
| 4. | Percentage of adults reporting 14 or more days of poor mental health | Prevention | BRFSS | NA | Survey | WA State Department of Health | High | X | X | | | | |
| 5. | Ambulatory Care Sensitive Condition Hospital Admissions: Chronic Obstructive Pulmonary Disease | Chronic | AHRQ-PQI (PQI 05) | 0275 | Claims | Alliance | Medium | X | X | | | | C/MC |
| 6. | Child and Adolescent Access to Primary Care Practitioners | Prevention | NCQA | NA | Claims | Alliance | High | X | X | X | | | C/MC |
| 7. | Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | Prevention | NCQA | 1516 | Claims | Alliance | High | X | X | X | | | C/MC |

[1] This is a summary/title of the measure proposed for inclusion in the "starter set." A summary of the measure definitions can be found starting on page 14. Some measures need further definition prior to implementation.
[2] This shows the technical measures work group which made this recommendation.
[3] This refers to the organization or agency that has developed and maintains the measure.
[4] Indicates whether the measure is NQF-endorsed and, if so, provides the NQF reference number.
[5] This refers to the type of data required to complete the measurement. This will either be health insurance claims, clinical data from the medical record extracted or self-reported by providers, or survey data.
[6] This specifies the specific source of data in Washington State that is readily available. Not all proposed measures are in current use.
[7] This is an assessment of our confidence level re: our ability to currently aggregate data, measure and report results for the starter set measure in the near term. Confidence is expressed as high, medium or TBD. Where confidence is noted as TBD, this indicates a measure that is not currently in use in Washington for public reporting and we are unsure about access to data, programming resources and results testing prior to implementation.
[8] One or more units of analysis are recommended for each measure. This delineates the level of measurement recommended for the starter set, i.e., the results will be available for this unit of analysis.
[9] Not all counties, medical groups or hospitals will have results that meet a minimum threshold for public reporting. This will be especially true for critical access hospitals, smaller medical groups and rural counties.
[10] Includes recommendations for if the measure should be stratified and, if so, how. C=Commercial; MC=Medicaid; M/F=gender; MC R/E=Race/Ethnicity (only applicable to Medicaid population). Not all measures will be stratified.
[11] Includes primary care and multi-specialty medical groups *with four or more providers*

| | Measure | WG | Steward | NQF # | Type of Data | Data Source | Confidence Level | Recommended Unit(s) of Analysis | | | | | Stratify |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | State-wide | County or ACH | Health Plan | Medical Group | Hospital | |
| 8. | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment | Prevention | NCQA | 0024 | Claims and Clinical Data | Health Plans | Medium | | | X | | | C/MC |
| 9. | Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers | Prevention | University of Minnesota | 1419 | Claims | WA State Health Care Authority/ Delta Dental | Medium | X | Maybe | X | | | C/MC |
| 10. | Adult Access to Preventive/ Ambulatory Health Services | Prevention | NCQA | NA | Claims | Alliance | High | X | X | X | | | C/MC |
| 11. | Adult BMI Assessment | Prevention | NCQA | NA | Claims and Clinical Data | Health Plans | Medium | X | | X | | | C/MC |
| 12. | Medical Assistance With Smoking and Tobacco Use Cessation (MSC) | Prevention | NCQA | 0027 | Survey | Health Plans | Medium | X | | X | Maybe | | |
| 13. | Colorectal Cancer Screening | Prevention | NCQA | 0034 | Claims | Alliance | High | X | X | X | In 2016 | | C/MC |
| 14. | Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | Chronic | NCQA | 0061 | Claims and Clinical Data | Health Plans | Medium | | | X | | | |
| 15. | Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | Chronic | NCQA | 0059 | Claims and Clinical Data | Health Plans | Medium | | | X | | | |
| 16. | Hypertension: Blood Pressure Control | Chronic | NCQA | 0018 | Clinical Data | Health Plans | Medium | | | X | | | |
| 17. | Follow-Up After Hospitalization for Mental Illness @ 7 days, 30 days | Acute | NCQA | 0576 | Claims | TBD[12] | TBD[12] | Maybe | Maybe | X | | | C, MC |
| 18. | 30-day Psychiatric Inpatient Readmission | Acute | Washington State (Homegrown) | NA | Claims | TBD[12] | TBD[12] | Maybe | Maybe | X | | | |
| 19. | Childhood Immunization Status | Prevention | NCQA | 0038 | Registry | WA DOH/ WA IIS | High | X | X | | X | | |
| 20. | Adolescent Immunization Status | Prevention | NCQA | 1407 | Registry | WA DOH/ WA IIS | High | X | X | | X | | |
| 21. | Human Papillomavirus (HPV) Vaccine for Adolescents | Prevention | NCQA | NA | Registry | WA DOH/ WA IIS | High | X | X | | X | | M/F |

[12] The Washington Health Alliance currently does not have access to claims information related to behavioral health. More work is needed to determine whether the data source for these measures will be the Alliance or the Health Plans directly.

| | Measure | WG | Steward | NQF # | Type of Data | Data Source | Confidence Level | Recommended Unit(s) of Analysis | | | | | Stratify |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | State-wide | County or ACH | Health Plan | Medical Group | Hospital | |
| 22. | Appropriate Testing for Children with Pharyngitis | Acute | NCQA | 0002 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 23. | Patient Experience (Outpatient)<br>• Provider Communication | Chronic | AHRQ | 0005 | Survey | Alliance | TBD | | | | X<br>Maybe | | |
| 24. | Screening: Cervical Cancer | Prevention | NCQA | 0032 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 25. | Screening: Chlamydia | Prevention | NCQA | 0033 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 26. | Screening: Breast Cancer | Prevention | NCQA | NA | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 27. | Pneumonia Vaccination Status for Older Adults | Prevention | NCQA | 0043 | Registry | WA DOH/ WA IIS | High | X | X | | X | | |
| 28. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | Acute | NCQA | 0058 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 29. | Avoidance of Imaging for Low Back Pain | Acute | NCQA | 0052 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 30. | Use of Appropriate Medications for Asthma | Chronic | NCQA | 0036 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 31. | Cardiovascular Disease: Use of Statins | Chronic | American College of Cardiology/American Heart Association | NA | Claims | Alliance | TBD | X | X | | X | | C/MC |
| 32. | COPD: Use of Spirometry Testing in Assessment and Diagnosis | Chronic | NCQA | 0577 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 33. | Diabetes Care: Hemoglobin A1c testing | Chronic | NCQA | 0057 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 34. | Diabetes Care: Eye Exam | Chronic | NCQA | 0055 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 35. | Diabetes Care: Screening for Nephropathy | Chronic | NCQA | 0062 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 36. | Depression: Medication Management | Chronic | NCQA | 0105 | Claims | Alliance | High | X | X | X | X | | C/MC, MC R/E |
| 37. | Medication Adherence - Proportion of Days Covered: 5 Rates by Therapeutic Category | Chronic | Pharmacy Quality Alliance (PQA) | 0541 | Claims | Alliance | TBD | X | X | | X | | C/MC |

| | Measure | WG | Steward | NQF # | Type of Data | Data Source | Confidence Level | Recommended Unit(s) of Analysis | | | | | Stratify |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | State-wide | County or ACH | Health Plan | Medical Group | Hospital | |
| 38. | Medication Safety: Annual Monitoring for Patients on Persistent Medications (ACE/ARB component) | Chronic | NCQA | NA | Claims | Alliance | TBD | X | X | X | X | | C/MC, MC R/E |
| 39. | Medications: Percent Generic (Antacid, Antidepressants, Statins, ACEs/ARBs, ADHD) | Chronic | Washington Health Alliance Home Grown | NA | Claims | Alliance | High | X | X | | X | | C/MC |
| 40. | Patient Experience (Inpatient)<br>• Communication about Medicines<br>• Discharge Information | Acute | CMS | 0166 | HCAHPS Survey | WSHA/ Hospital Compare | High | X | | | | X | |
| 41. | 30-Day All-Cause Hospital Readmissions | Acute | NCQA | 1768 | Claims | Alliance | Medium | X | X | X | X | X | C/MC |
| 42. | Potentially Avoidable ED visits | Acute | Medi-Cal | NA | Claims | Alliance | High | X | X | | X | X | C/MC |
| 43. | Percent of Patients with 5 or More Visits to the Emergency Room *without* a Care Guideline | Acute | NA | NA | Clinical | WHSA/EDIE | High | X | | | | X | |
| 44. | Exclusive Breast Milk Feeding | Prevention | The Joint Commission | 0480 | Claims and Clinical Data | WSHA | Medium | | | | | X | |
| 45. | Cesarean Section - NTSV C-Section | Acute | The Joint Commission | 0471 | Claims and Clinical Data | WSHA | Medium | X | | | | X | |
| 46. | 30-day Mortality: Heart Attack(AMI) | Acute | CMS | 0230 | Claims and Clinical | WSHA/ Hospital Compare | High | X | | | | X | |
| 47. | Catheter-Associated Urinary Tract Infection | Acute | CDC | 0138 | Clinical | WSHA | High | X | | | | X | |
| 48. | Stroke: Thrombolytic Therapy | Acute | The Joint Commission | 437 | Clinical Data | WSHA | High | X | | | | X | |
| 49. | Falls with Injury Per Patient Day (adult acute care only) | Acute | WA DOH/ American Nurses Association | 0202 | WHSA | WSHA | High | X | | | | X | |
| 50. | Complications/Patient Safety for Eleven Selected Indicators (Composite) | Acute | AHRQ | 0531 | Claims | WSHA/ Hospital Compare | High | X | | | | X | |

| | Measure | WG | Steward | NQF # | Type of Data | Data Source | Confidence Level | Recommended Unit(s) of Analysis | | | | | Stratify |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | State-wide | County or ACH | Health Plan | Medical Group | Hospital | |
| 51. | Annual State-purchased Health Care Spending Growth Relative to State GDP | Chronic | Washington State (Homegrown) | NA | Claims | Health Care Authority | High | X | X | | | | |
| 52. | Medicaid Per Enrollee Spending | Chronic | Washington State (Homegrown) | NA | Claims | Health Care Authority | High | X | X | | | | *See note page 21 |
| 53. | Public Employee/Dependent Spending per Enrollee (Include Public Schools) | Chronic | Washington State (Homegrown) | NA | Claims | Health Care Authority | High | X | X | | | | *See note page 21 |

## Looking to the Future – Topics for Inclusion in a FUTURE Measure Set

During the three work groups' meetings, it was common to come upon topics that were considered very important but for one reason or another, we were unable to recommend a specific measure for inclusion in the starter set. In some cases, the work groups considered specific, potential measures, and in other cases when measures were unavailable, general topics were discussed. Generally speaking, these topics were not considered for the "starter set" for one or both of the following reasons: (1) there are currently no nationally vetted measures that are relevant to a broad cross section of the population for this topic area; and/or (2) there is no data source readily available within the state of Washington to enable credible measurement and public reporting. This was particularly problematic when considering health care outcomes which more often than not require clinical data abstracted from either electronic or paper-based medical records. We expect this to change over the next several years as more health care organizations and medical groups have access to (and the internal capability to utilize) electronic health records to support population level reporting, and a statewide Health Information Exchange infrastructure that will support clinical data aggregation, measurement and public reporting of outcomes.

Across the three work groups, 28 topics were identified for what became known as our "**high priority development list**" (sometimes also referred to as "the parking lot" for shorthand).

A survey was undertaken with key stakeholders involved in this process to prioritize this list of 28 topics. Survey respondents were asked to identify their ten highest priorities from the list of 28 topics. Sixty-five individuals were asked to respond to the survey; all individuals were members of the Performance Measures Coordinating Committee and/or one (or more) of the three technical work groups. Responses were collected from 59 individuals for a 91% response rate. To see a list of participants in this survey/prioritization process, please refer to Appendix D.

**The results of the survey are listed on the next page. The technical measures workgroups had a few specific comments about prioritization (in response to public comments) that are shown below in *italics*.**

## Looking to the Future – Topics for Inclusion in a FUTURE Measure Set

**TOP TIER PRIORITIZATION**: More than 50% of respondents indicated that the following seven topic areas should be considered the highest priorities for measure/data development and inclusion in a FUTURE iteration of Washington's Statewide Measure Set. The following list is shown in priority order (#1 is top priority) based on survey results.

1. Screening for Depression
2. Care Transitions Following Hospital Discharge
3. Hypertension Management
4. Diabetes Care: Development/Use of a Composite Measure
5. Elementary School-entry Immunization Status
6. Continuity of Care/Medication Reconciliation
7. Assessment of Patient Functional Status: Effective Chronic Illness Management

**SECOND TIER PRIORITIZATION**: Between 30% and 49% of respondents indicated that that the following six topic areas should be considered the highest priorities for measure/data development and inclusion in a FUTURE iteration of Washington's Statewide Measure Set. The following list is shown in priority order based on survey results.

8. Pediatric Asthma Control, Medication Management
9. ***Substance Abuse Screening, Brief Intervention and Referral; Substance Abuse Treatment/ Service Penetration -- The Chronic Care Measures Workgroup recommends that this be moved to the top tier prioritization list for future measurement when feasible.***
10. Major Depression Disorder Control
11. Patient Safety: Rate of Adverse Events and Never Events
12. ***Continuity of Care: Advanced Care Planning – The Chronic Care Measures Workgroup considers this a high priority topic for further consideration; however, they expressed concern about this area for measurement and public reporting, noting that "not everything that counts can be counted."***
13. ***Mental Health Service Penetration – See comment for #9.***

**REMAINING TOPIC AREAS**: Fewer than 30% of respondents indicated that the following topic areas should be considered the highest priorities for measure/data development and inclusion in a FUTURE iteration of Washington's Statewide Measure Set. The following list is shown in descending order of prioritization based on survey results.

- Cancer Care: Chemotherapy within the Last 14 Days of Life
- COPD: Compliance and Therapy
- Obstetrics: Low Birth Weight
- Prevention: Assessment and Counseling for Risky Behavior
- Obstetrics: Non Medically-Indicated Inductions
- Diabetes Care: Use of Statins
- Obstetrics: Routine Pre-and Post-Partum Care
- Prevention: Assessment for Adverse Childhood Trauma
- Adult Asthma: Control, Medication Management
- Prevention: Breast Feeding
- Cardiovascular Disease: Time of Transfer for Acute Coronary Intervention
- Attention Deficit/Hyperactivity Disorder: Follow-up Care for Children
- Cancer Care: Other (TBD)
- Prevention: Assessment for Domestic Violence

# HEALTH CARE COST MEASURES

A second question in the survey related to FUTURE health care cost[13] measures in Washington once an infrastructure is in place that enables (1) the routine collection of priced claims from all public and private payers in the state, and (2) regular measurement and reporting with multi-payer results. Survey respondents were asked to rank order the following three options for measure development for inclusion in a future iteration of Washington's Statewide Performance Measure Set. Although the results below are shown in priority order, it is worth noting that the scoring was very close and many respondents commented that **ALL THREE should be considered a priority for future work**.

1. **Cost of Potentially Avoidable Services:** Measurement and reporting in this area would add a realistic price tag to quantify potentially avoidable services such as ambulatory-sensitive hospital admissions, hospital readmissions, complications, emergency department visits and Choosing Wisely procedures and diagnostic testing. The information would help to (1) inform purchasers and others about how potentially avoidable services are specifically contributing to the overall cost trend, (2) prioritize interventions to reduce potentially avoidable events, and (3) formulate a message suitable for public audiences about the cost burden associated with potentially avoidable services.

2. **Total Cost of Care for Specified Populations:** Measurement and reporting in this area would reveal the total cost associated with the care of a population attributed to a specific provider organization (e.g., accountable care organization, integrated delivery system, medical group).

3. **Pricing for Types of Treatment:** Measurement and reporting would compare the episode price for similar treatments and procedures (e.g., back surgery, joint replacement, C-section, angioplasty**)** adjusting for how sick patients are. This information would reveal the extent of cost differences between delivery systems, whether providers are working together as employees of the health system or as independent contractors because it bundles together professional and facility fees to provide an overall price for the episode. This reporting would enable a multi-payer view of these prices (i.e., blended average).

[13] *Note: the word 'cost' in the context of this report means the actual transaction prices between buyer(s) of health care services and provider(s). It does not refer to the premiums paid by companies or individuals to insurance carriers (although in bending the cost curve, we certainly would expect premiums to moderate as well). It also does not refer to the internal costs or expenses incurred by provider organizations to deliver care.*

## Appendix A: Summary - Measure Definitions *(Order of measures matches the order of measures included in the diagram on page 6 of this report.)*

| | Measure | Summary of Measure Definition |
|---|---|---|
| 1. | Influenza Immunization | Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization |
| 2. | Unintended Pregnancies | Percent of pregnancies that were unintended at time of conception. This does have a data source through the CDC Pregnancy Risk Assessment Monitoring System (PRAMS), which is collected by Department of Health at the state level. |
| 3. | Percentage of adults who smoke cigarettes | Numerator: # of adults ages 18 and older who answer "every day" or "some days" in response to the question, "Do you now smoke cigarettes every day, some days, or not at all?" Denominator: # of adults age 18 and older who answer this question. |
| 4. | Percentage of adults reporting 14 or more days of poor mental health | Percentage of adults ages 18 and older who answer "14 or more days" in response to the question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" |
| 5. | Ambulatory Care Sensitive Condition Hospital Admissions: Chronic Obstructive Pulmonary Disease (PQI 05) | Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions. |
| 6. | Child and Adolescent Access to Primary Care Practitioners (CAP) | Percentage of children and adolescents ages 12months to 19 years that had a visit with a PCP, including four separate percentages:<br>• Children ages 12 to 24 months and 25 months to 6 years who had a visit with a PCP during the measurement year<br>• Children ages 7 to 11 years and adolescents ages 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year |
| 7. | Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34) | Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year |
| 8. | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents (WCC) | Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender; requires clinical data |
| 9. | Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers | The measure tracks the extent to which the PCP or clinic (determined by the provider number used for billing) applies FV as part of the EPSDT examination |
| 10. | Adult Access to Preventive/Ambulatory Health Services (AAP) | The percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit. |
| 11. | Adult BMI Assessment (ABA) | The percentage of members 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. Requires clinical data; results only available at health plan level. |
| 12. | Medical Assistance With Smoking and Tobacco Use Cessation (MSC) | Uses patient experience survey (CAHPS) to assess different facets of providing medical assistance with smoking and tobacco use cessation:<br>• Advising Smokers and Tobacco Users to Quit<br>• Discussing Cessation Medications<br>• Discussing Cessation Strategies |
| 13. | Colorectal Cancer Screening (COL) | Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer; requires 10 years of data for full look back period |
| 14. | Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure reading is <140/90 MM hg during the measurement year. Requires clinical data; results only available at health plan level for starter set |

| | Measure | Summary of Measure Definition |
|---|---|---|
| 15. | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c > 9.0% during the measurement year. Requires clinical data; results only available at health plan level for starter set |
| 16. | Hypertension: Controlling High Blood Pressure | The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Requires clinical data; results only available at health plan level for starter set |
| 17. | Follow-Up After Hospitalization for Mental Illness (FUH) | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1) the percentage of members who received follow-up within 30 days of discharge, 2) the percent of members who received follow-up within 7 days of discharge |
| 18. | Psychiatric Inpatient Readmissions | For members 18 years of age and older, the number of acute inpatient psychiatric stays during the measurement year that were followed by an acute readmission for a psychiatric diagnosis within 30 days |
| 19. | Childhood Immunization Status (CIS) | Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday |
| 20. | Adolescent Immunization Status (AIS) | Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday |
| 21. | Human Papillomavirus (HPV) Vaccine for Adolescents | Percentage of adolescents 13 years of age (male and female) who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. |
| 22. | Appropriate Testing for Children with Pharyngitis (CWP) | Percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode |
| 23. | Patient Experience: Provider Communication | 52-items survey instrument (CG-CAHPS) with 3 domain-level composites. Work group selected one composite measure in particular (Provider Communication, composite of 6 survey questions)) as it correlates with improved outcomes; Top Box scores to be reported |
| 24. | Cervical Cancer Screening (CCS) | Percentage of women 21-64 years of age who received PAP test to screen for cervical cancer. (interval every 3 years) |
| 25. | Chlamydia Screening (CHL) | Percentage of women ages 16 to 24 that were identified as sexually active and had at least one test for Chlamydia during the measurement year |
| 26. | Breast Cancer Screening | The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. (interval =1x/27 months) |
| 27. | Pneumonia Vaccination Status for Older Adults (PNU) | Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine |
| 28. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) | The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. |
| 29. | Avoidance of Imaging Studies for Low Back Pain | This measure calculates the percentage of patients 18-50 years with a diagnosis of lower back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis. |
| 30. | Use of Appropriate Medications for Asthma (ASM) | Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. |
| 31. | Cardiovascular Disease: Use of Statins | The percentage of patients ages 18 to 75 with heart disease (coronary artery disease or CAD) who had at least one prescription filled to lower cholesterol (lipid-lowering therapy, based on current American College of Cardiology /American Heart Association guidelines) during a one-year period. |
| 32. | Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) | The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. |
| 33. | Comprehensive Diabetes Care: Hemoglobin A1c testing | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year. |
| 34. | Comprehensive Diabetes Care: Eye Exam | Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period |
| 35. | Comprehensive Diabetes Care: Medical Attention for Nephropathy | The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period. |
| 36. | Anti-depressant Medication Management (AMM) | Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported: 12 weeks and 6 months. |

| | Measure | Summary of Measure Definition |
|---|---|---|
| 37. | Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category | Percentage of patients 18 years and older who met the proportion of days covered threshold of 80% during the measurement year. Rate is calculated separately for the following medication categories: Beta Blockers, ACEI/ARB, Calcium-Channel Blockers, Diabetes Medication, Statins |
| 38. | Annual Monitoring for Patients on Persistent Medications (ACE/ARB component) | Percent of patients who received 180 treatment days of ACE inhibitors or ARBs during the measurement year who had at least one serum potassium and either a serim creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Considered a patient safety measure. |
| 39. | Pharmacy: Percent Generic | One rate for each: Percentage of Generic Prescriptions for ACE inhibitors or angiotensin II receptor blockers (ARBs), attention deficit hyperactivity disorder(ADHD) Medications, PPIs (proton pump inhibitors), SSRIs, SNRIs, and other Second Generation Antidepressants, Statins |
| 40. | HCAHPs<br>• Medicines Explained<br>• Discharge Information | 27-items survey instrument with 7 domain-level composites. Work group selected two in particular (Communication about Medicines and Discharge Information) as they relate specifically to improving care transitions and reducing hospital readmissions. |
| 41. | 30-day All-Cause Hospital Readmission | For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:<br>1. Count of Index Hospital Stays (denominator) - Observed<br>2. Count of 30-day readmissions (numerator) - Observed<br>3. Average Risk Adjusted Probability of Readmission - Expected |
| 42. | Potentially Avoidable ED visits | Avoidable emergency visits using the Medi-Cal Diagnosis list to identify potentially avoidable ED visits; considered very conservative measure. |
| 43. | Percent of Patients with Five or More Visits to the Emergency Room without a Care Guideline | Percent of patients with 5 or more visits to the Emergency Room without a Care Guideline; data comes from EDIE. |
| 44. | Exclusive Breast Milk Feeding | This measure assesses the number of newborns exclusively fed breast milk feeding during the newborn´s entire hospitalization. The numerator includes newborns that were fed breast milk only since birth. The denominator includes single term live born newborns discharged from the hospital (Diagnosis codes and exclusions defined in measure specs). |
| 45. | PC-02: Cesarean Section - NTSV C-Section [Nulliparous (first baby), Term (>37 weeks), Singleton (one baby), and (head down)] | This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is a part of a set of five nationally implemented measures that address perinatal care |
| 46. | 30-Day Heart Attack Mortality | The measure estimates a hospital 30-day risk-standardized mortality rate (RSMR), defined as death for any cause within 30 days after the date of admission of the index admission, for patients 18 and older discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). CMS annually reports the measure for patients who are 65 years or older and are either enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are hospitalized in Veterans Health Administration (VA) facilities. |
| 47. | Catheter-Associated Urinary Tract Infection | Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations:<br>• Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries])<br>• Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • Other inpatient locations (excluding Level I and Level II nurseries).<br>Only locations where patients reside overnight are included. |
| 48. | STK-4: Thrombolytic Therapy | This measure captures the proportion of acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well for whom IV t-PA was initiated at this hospital within 3 hours of time last known well. This measure is a part of a set of eight nationally implemented measures that address stroke care that are used in The Joint Commission's hospital accreditation and Disease-Specific Care certification programs. |

| | Measure | Summary of Measure Definition |
|---|---|---|
| 49. | Falls with Injury Per Patient Day (adult acute care and rehabilitation only) | Falls with Injury per patient day (adult acute care only) – Need to agree upon specific numerator/denominator specs; more than one measure available |
| 50. | PSI-90: Complications/Patient Safety for Selected Indicators (Composite) | A composite measure of 11 potentially preventable adverse events for selected indicators. The weighted average of the observed-to-expected ratios for the following component indicators are included (but not reported separately):<br>• PSI #3 Pressure Ulcer Rate<br>• PSI #6 Iatrogenic Pneumothorax Rate<br>• PSI #7 Central Venous Catheter-Related Blood Stream Infection Rate<br>• PSI #8 Postoperative Hip Fracture Rate<br>• PSI #9 Perioperative Hemorrhage or Hematoma Rate<br>• PSI #10 Postoperative Physiologic and Metabolic Derangement Rate<br>• PSI #11 Postoperative Respiratory Failure Rate<br>• PSI #12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate<br>• PSI #13 Postoperative Sepsis Rate<br>• PSI #14 Postoperative Wound Dehiscence Rate<br>• PSI #15 Accidental Puncture or Laceration Rate |
| 51. | Annual State-purchased Health Care Spending Growth Relative to State GDP | TBD |
| 52. | Medicaid Per Enrollee Spending | TBD: Total Medicaid Spending in CY/Total # of Medicaid Beneficiaries in CY; it will be important to adjust this measure for the different types of Medicaid populations. |
| 53. | Public Employee and Dependent per Enrollee Spending | TBD: Total State Spending for Public Employees and Dependents (include Public Schools) in CY/Total # of Beneficiaries in CY |

## Appendix B: Comments *(Order of measures matches the order of measures included in the diagram on page 6 of this report.)*

| | Measure | Opportunity for Improvement and Other Comments |
|---|---|---|
| 1. | Influenza Immunization | Opportunity to improve in absolute terms: 45.7% per the CDC (this is not an exact benchmark).<br>Concern about the extent to which the WA IIS captures complete data for this measure. WA IIS staff report that the data is getting more complete, and if the measure is included on the list, then providers may focus more on reporting the data. |
| 2. | Unintended Pregnancies | State rate is 49% per DOH; this falls short of the Health People 2020 goal of 44% and is poor in absolute terms.<br>Unintended pregnancy is associated with an increased risk of problems for the mother and baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing and/or not have a stable socio economic environment in which to introduce a baby. In 2010, there were an estimated 52,500 unintended pregnancies in Washington. |
| 3. | Percentage of adults who smoke cigarettes | State performance at 16% for "everyday" or "some days." This is near the national average of 18.8% per the 2013 BRFSS survey and there is opportunity for improvement in absolute terms. |
| 4. | Percentage of adults reporting 14 or more days of poor mental health | State performance is at 11.6%. This is essentially the same as the national average at 11.9%, per the 2011 BRFSS survey and there is opportunity for improvement in absolute terms. |
| 5. | Ambulatory Care Sensitive Condition Hospital Admissions: Chronic Obstructive Pulmonary Disease (PQI 05) | State rate at 1.32% is better than the national average, but benchmark source is non-exact[14] (WA MONAHRQ 2009).<br>Measure included in recommended starter set because COPD important and growing problem among the working age population (in addition to older adults), based on National Business Coalition on Health 2012 Action Brief on COPD. Results only available at the state level only because denominator is small. |
| 6. | Child and Adolescent Access to Primary Care Practitioners (CAP) | Commercial 12-19 year rate of 89% is below the national average of 97% and the commercial 25-months to 6 year rate of 88% is at the national average and below the national 90$^{th}$ percentile. All other commercial and Medicaid rates exceed 90% and the national 90$^{th}$ percentile.<br>Included in recommended starter set because it is a priority to monitor access to primary care for children, particularly given the large expansion of this population through Medicaid and the Exchange. |
| 7. | Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34) | Both commercial and Medicaid rates are at the national averages.<br>In the absence of good data for elementary school entry immunizations, the work group recommends including this measure for well-child visits as a proxy to keep a focus on school-based wellness and immunizations. |
| 8. | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents (WCC) | Commercial rates for BMI Assessment, Counseling for Nutrition and Counseling for Physical Activity all equal the respective national averages and are low in absolute terms (<50%); Medicaid rates for BMI Assessment and Counseling for Nutrition are far below the respective national averages. Only Counseling for Physical Activity exceeds the national average (51%), but it has opportunity for improvement in absolute terms.<br>Difficult measure to capture and report reliably, but very important public health concern. Results only available at the health plan level for starter set. |
| 9. | Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers | No information currently available regarding opportunity for improvement in WA. This measure is recommended for Meaningful Use Stage Two and is a B-level recommendation of USPHSTF; also in Physician Quality program. System for measurement across payer types not now in place; however, Delta Dental has formally offered to provide aggregated results from claims data; Medicaid will also provide data. Will need to work specifically on data aggregation and determine how to operationalize this measure. |

[14] There are a few occasions in which baseline and benchmark information could be identified, but only for a similar measure, and not for the exact recommended measure.

| | Measure | Opportunity for Improvement and Other Comments |
|---|---|---|
| 10. | Adult Access to Preventive/Ambulatory Health Services (AAP) | Commercial rate is at the national 90th percentile. There is no Washington-specific reporting for Medicaid for this measure by NCQA.<br>Included in recommended starter set because it is a priority to monitor access to primary care for adults, particularly given the large expansion of this population through Medicaid and the Exchange. |
| 11. | Adult BMI Assessment (ABA) | Commercial rate is at the national average and below the national 90th percentile. There is no Washington-specific reporting for Medicaid for this measure by NCQA. Difficult measure to capture and report reliably, but very important public health concern. Results only available at the health plan level for starter set. |
| 12. | Medical Assistance With Smoking and Tobacco Use Cessation (MSC) | Commercial and Medicaid rates both below the national average.<br>The work group recommends the state provide resources to ensure that the CG-CAHPS survey is continued and expanded statewide to enable medical group level reporting. Otherwise, this measure will only be reported at the health plan level based on the Health Plan CAHPS survey. |
| 13. | Colorectal Cancer Screening (COL) | Commercial rate is below the national 90th percentile; Medicaid information is not available through NCQA.<br>For the starter set, conduct as a claims-only measure. Note: if the state is interested in having national benchmarks for this claims-based measure, then it will need to provide resources to purchase this information from NCQA. |
| 14. | Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | Commercial rate at 59% is below the national average of 62%; Medicaid rate at 53% is below the national average of 60%.<br>Important clinical outcome measure but no infrastructure for provider-level reporting so starter measure focused on health plan-level results. |
| 15. | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | State commercial rate at 37% is worse than the national average at 34%; Medicaid rate at 55% is worse than the national average at 45%.<br>Important clinical outcome measure but no infrastructure for provider-level reporting so starter measure focused on health plan-level results |
| 16. | Hypertension: Controlling High Blood Pressure | Commercial rate at 55% is below the national average of 62%; there is no Washington-specific reporting for Medicaid for this measure by NCQA.<br>Important clinical outcome measure but no infrastructure for provider-level reporting so starter measure focused on health plan-level results. |
| 17. | Follow-Up After Hospitalization for Mental Illness | Commercial performance is below national 90th percentile; Medicaid performance is below national average.<br>Mixed opinion about the importance/relevance of this measure; ultimately work group concluded that it is important process measure in support of the psychiatric inpatient readmission measure. |
| 18. | Psychiatric Inpatient Readmission | New measure specifications provided by DSHS; not yet nationally vetted. Testing has only occurred using Medicaid data; has not been used with commercial data but appears to be "doable." No identified baseline or benchmark. |
| 19. | Childhood Immunization Status (CIS) | Commercial and Medicaid rates are below the national 90th percentile.<br>Strong work group support for all immunization measures; DOH has indicated that they can produce results by medical group, county and state. |
| 20. | Adolescent Immunization Status (AIS) | Commercial rate is below the national average; Medicaid rate is below the national 90th percentile.<br>Strong work group support for all immunization measures; DOH has indicated that they can produce results by medical group, county and state. |
| 21. | Human Papillomavirus (HPV) Vaccine for Adolescents | Opportunity to improve in absolute terms (45.5%, females 13-17 yrs per the CDC) and relative to Healthy People 2020 goal (80%, females 13-15 yrs). Not an exact benchmark.<br>Work group recommends modifying the measure to include males (but following the same specifications otherwise). The work group recognizes that the NCQA benchmarks would not be applicable to this measure. Stratify the data to examine females and males separately. |
| 22. | Appropriate Testing for Children with Pharyngitis | Commercial and Medicaid performance both at national average, based on NCQA benchmarks for commercial and managed Medicaid plans (CY2013). |
| 23. | Patient Experience: Provide Communication (Top Box "Always") | Regional average is 79% with range of medical group performance from 61.6% - 90.8%. Results declined for this measure from 2011 – 2013. |
| 24. | Cervical Cancer Screening | Commercial and Medicaid rates are both at the national average.<br>Strong endorsement from work group, actionable; disparities in care a challenge. Interest in seeing future iteration of this measure also including HPV (in addition to PAP). |

| | Measure | Opportunity for Improvement and Other Comments |
|---|---|---|
| 25. | Chlamydia Screening | Commercial rate is below the national 90th percentile; Medicaid rate is below the national average.<br>Strong endorsement from work group; lack of prevention results in significant morbidity (not mortality), actionable. Disparities in care a challenge. |
| 26. | Breast Cancer Screening | Commercial and Medicaid rates are both at the national average. Utilize the HEDIS 2015 Breast Cancer screening measure specifications; expect this new spec to be NQF-endorsed. |
| 27. | Pneumonia Vaccination Status for Older Adults | State performance at 72.8% is near the national rate of 67.7% per the 2012 BRFSS survey and there is opportunity for improvement in absolute terms. |
| 28. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | Regional average at 25%. Commercial and Medicaid rates are both at the national average. *Significant* room for improvement, particularly in comparison to measure on avoiding antibiotic treatment for URI at 93%. |
| 29. | Use of Imaging Studies for Low Back Pain | Overall performance in the state is relatively strong compared to national benchmarks (Puget Sound region at 86%), but still considerable variation among medical groups indicating room for improvement; important to keep a focus on this. |
| 30. | Use of Appropriate Medications for Asthma | Commercial regional rate is at 92%, above the national average but below the 90th percentile; Medicaid rate is at the national average. |
| 31. | Cardiovascular Disease: Use of Statins | National studies show that patients don't fill statins for over one-third of scripts and only half continue to take statins during the six months post-prescription and only 30-40% continue taking them after 12 months. Alliance measurement indicates an opportunity for improvement in absolute terms (no external benchmark available). Current regional average for Puget Sound area is 73%, with a range among medical groups of 63% - 82%. |
| 32. | Use of Spirometry Testing in the Assessment and Diagnosis of COPD | Commercial and Medicaid rates are at the national average and below the 90th percentile. Current regional average for Puget Sound area is 51%.<br>NCQA is considering retiring *for accreditation purposes* due to concerns about measure set size and an increasing focus on outcome measures, but has no plans to remove the measure from the HEDIS measure set per NCQA, 8/2014. |
| 33. | Comprehensive Diabetes Care: Hemoglobin A1c testing | Commercial and Medicaid both at national average; Puget Sound regional average for commercial is 90%. Relatively smaller opportunity for improvement, but remains important process measure for diabetes care. |
| 34. | Comprehensive Diabetes Care: Eye Exam | Commercial rate is at the national average; Puget Sound regional rate is at 67%. |
| 35. | Comprehensive Diabetes Care: Medical Attention for Nephropathy | Commercial rate (86%) is at the national average; Medicaid rate is below the national average.<br>Relatively smaller opportunity for improvement, but remains important process measure for diabetes care. |
| 36. | Anti-depressant Medication Management | Commercial and Medicaid both at the national average. Puget Sound regional average at 53% for significant room for improvement in absolute terms. |
| 37. | Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category | CMS Five Star Ratings categorize health plans into five levels based on performance. *No specific information yet identified for WA plans.*<br>New measure for WA/Alliance – will need to be programmed and tested against data |
| 38. | Annual Monitoring for Patients on Persistent Medications (ACE/ARB component) | Commercial rate (82.8%) is below the national 90th percentile (86.6%); Medicaid average (85.6%) is below the national 90th percentile (91.2%).<br>New measure for WA/Alliance – will need to be programmed and tested against data |
| 39. | Pharmacy: Percent Generic (one rate for each: Antacid, Antidepressants, Statins, ACEs and ARBs, ADHD) | There are five measure components. In four out of the five drug classes the Puget Sound regional average falls below the Alliance target: PPI = 89% (compared to 95% target); Antidepressants = 92% (compared to 95% target); Statins = 81% (compared to 95% target); ACE/ARB = 81% (compared to 90% target). No target has yet been set for the ADHD class (current performance = 65%). Considerable discussion re: this measure with input from non-work group members/organizations; relatively strong performance on generic prescribing for state as a whole, but still considerable variation among medical groups and individual providers. |
| 40. | HCAHPs<br>• Medicines Explained<br>• Discharge Information | Work group selected two in particular (Communication about Medicines and Discharge Information) as they relate specifically to improving care transitions and reducing hospital readmissions. The work group excluded the rest of the composites. This will be included as two separate results.<br>Medicines Explained: State average is 64% (same as national average of 64%); well below best performing hospital nationally at 98%.<br>Discharge Information: State average is 87%% (higher than national average of 85%); below best performing hospital nationally at 95%. |

| | Measure | Opportunity for Improvement and Other Comments |
|---|---|---|
| 41. | 30-Day All-Cause Hospital Readmission | Alliance *draft* results shows regional commercial performance (8.9%) close to but worse than NCQA 50th percentile (8.3%); no Medicaid benchmark available. NQF is revisiting readmission measures this Fall to merge/modify CMS and NCQA measures (or select between the two). |
| 42. | Potentially Avoidable ED visits | The Alliance utilizes this measure today for both the commercial and Medicaid populations and reports the results separately. It is a *VERY conservative estimate* of potentially avoidable ED visits; current reporting indicates approximately 9-10% of visits are avoidable. |
| 43. | Percent of Patients with Five or More Visits to the Emergency Room without a Care Guideline | WSHA will need to provide baseline and benchmark; no information available for this report. |
| 44. | Exclusive Breast Milk Feeding | There is strong evidence in support of breast feeding (USPSTF recommendation), (2) the breastfeeding measure is a Joint Commission measure, (3) hospitals (with TJC accreditation) are already collecting this data and (4) WSHA has committed to help collect results from this measurement for hospitals with $\geq$ 1,100 births per year. |
| 45. | PC-02: Cesarean Section - NTSV C-Section [Nulliparous (first baby), Term (>37 weeks), Singleton (one baby), and (head down)] | State rate appears to be about 25%; performance is not aligned with the Healthy People 2020 goal of 23.9%; and, there is significant variation across the state (15 - 46%). Not clear what the state's goal is.<br>PC-02 and the Healthy People 2020 are the same measure, but are described slightly differently. The methodology is the same, however. |
| 46. | MORT-30-AMI: Heart Attack Mortality | 44 WA hospitals are the same as the national average (15.2%) and no hospitals are better than average. 40 hospitals had too few cases.<br>Strong system measure. |
| 47. | Catheter-Associated Urinary Tract Infection | WA State Standardized Infection Ratio (1.167) exceeds the predicted score (1.00) per CMS' Hospital Compare. SIRs above 1.00 mean the state had more HAIs than were predicted. Currently measured and available; outcome measure with good opportunity for improvement. |
| 48. | STK-4: Thrombolytic Therapy | State rate (73%) exceeds the national rate (66%) per CMS' Hospital Compare, but there is an opportunity for improvement in absolute terms.<br>This is the most important measure in treating stroke and a major state initiative. While state is performing better than national average, there is still room for improvement. |
| 49. | Falls with Injury Per Patient Day | Data are being collected by WSHA for 7/1/14 - 12/31/14. No benchmark available on CMS' Hospital Compare. |
| 50. | PSI-90: Complications/Patient Safety for Selected Indicators (Composite) | Six hospitals worse than average (0.61), 42 same as average, no hospitals better than average, and 0 hospitals had too few cases, all per CMS' Hospital Compare. Concerns regarding the reliability of data components within claims, e.g., PSI#7 |
| 51. | Annual State-purchased Health Care Spending Growth Relative to GDP | No identified baseline or benchmark. Measure specification will need to be agreed upon |
| 52. | Medicaid Per Enrollee Spending | State spending ($4,849) falls below the national average ($5,563) per the Kaiser Family Foundation.<br>Measure specification will need to be agreed upon; If possible, stratify by primary care, specialty care, hospital inpatient/outpatient, emergency and other spending categories of interest. |
| 53. | Public Employee and Dependent per Enrollee Spending | No identified baseline or benchmark. Measure specification will need to be agreed upon; if possible, stratify by primary care, specialty care, hospital inpatient/outpatient, emergency and other spending categories of interest. |

# Appendix C: Work Group Members

### PREVENTION MEASURES WORK GROUP

| | |
|---|---|
| Jennifer Allen | Planned Parenthood Votes Northwest |
| Joan Brewster | Grays Harbor Public Health & Social Services |
| Ian Colbridge | WA State Hospital Association |
| Bev Green | Group Health Research Institute |
| Jeffrey Harris | UW Health Promotion Research Center |
| Jesus Hernandez | Community Choice (Wenatchee) |
| Dan Kent | Premera Blue Cross |
| Mark Koday | Yakima Valley Farmworkers Clinic |
| Mary Kay O'Neill | Regence Blue Shield |
| Janet Piehl | UW Neighborhood Clinics |
| Bailey Raiz | Community Health Plan of WA |
| Kyle Unland | Spokane Regional Health District |
| Kristen Wendorf | Seattle King County Public Health |

### CHRONIC ILLNESS MEASURES WORK GROUP

| | |
|---|---|
| Christopher Dale | Swedish Health Services |
| Stacey Devenney | Kitsap Mental Health Services |
| Erin Hafer | Community Health Plan of WA |
| Kimberley Herner | UW/Valley Medical Center Clinic Network |
| Jutta Joesch | King County |
| Dan Kent | Premera Blue Cross |
| Julie Lindberg | Molina Health Care of Washington |
| Paige Nelson | The Everett Clinic |
| Kim Orchard | Franciscan Health System |
| Larry Schecter | WA State Hospital Association |
| Julie Sylvester | Qualis Health |

### ACUTE CARE MEASURES WORK GROUP

| | |
|---|---|
| Connie Davis | Skagit Regional Health |
| Mark Delbeccaro | Seattle Childrens |
| Tim Dellit | University of Washington |
| Sue Dietz | Critical Access Hospital Network |
| Jennifer Graves | WA State Nurses Association |
| Patrick Jones | Eastern WA University Institute for Public Policy and Economic Analysis |
| Kim Kelley | DOH Critical Access Hospital Program |
| Dan Kent | Premera Blue Cross |
| Michael Myint | Swedish Health Services |
| Terry Rogers | Foundation for Healthcare Quality |
| Carol Wagner/Larry Schecter | WA State Hospital Association |

# Appendix D:

## Invited/Responded to Survey on Prioritization of Topics for Future Measure Sets:

| Name | | Organization | Performance Measures Coordinating Committee | Prevention Workgroup | Acute Care Workgroup | Chronic Illness Workgroup |
|---|---|---|---|---|---|---|
| Jennifer | Allen | Planned Parenthood Votes Northwest | | X | | |
| Chris | Barton | SEIU Health Care 1199NW Nurse Alliance | X | | | |
| Jane | Beyer | WA State Department of Social and Health Services | X | | | |
| Craig | Blackmore | Virginia Mason Health System | X | | | |
| Gordon | Bopp | National Alliance on Mental Illness - WA | X | | | |
| Joan | Brewster | Grays Harbor Public Health & Social Services | | X | | |
| Patrick | Bucknam | Columbia Valley Community Health | X | | | |
| Fred | Chen | University of Washington Medicine | X | | | |
| Ann | Christian | WA Community Mental Health Council | X | | | |
| Ian | Colbridge | WA State Hospital Association | | X | | |
| Vic | Collymore | Community Health Plan of Washington | X | | | |
| Patrick | Connor | WA Chapter, National Federation of Independent Business | X | | | |
| Jessica | Cromer | Amerigroup Washington | X | | | |
| Chris | Dale | Swedish Health Services | | | | X |
| Connie | Davis | Skagit Regional Health | | | X | |
| Mark | Delbeccaro | Seattle Childrens | | | X | |
| Tim | Dellit | University of Washington | | | X | |
| Stacey | Devanney | Kitsap Mental Health Services | | | | X |
| Sue | Dietz | Critical Access Hospital Network | X | | X | |
| John | Espinola | Premera Blue Cross | X | | | |
| Gary | Franklin | WA State Labor and Industries | X | | | |
| Teresa | Fulton | Whidbey General Hospital | X | | | |
| Nancy | Giunto | Washington Health Alliance | X | | | |
| Jennifer | Graves | Washington State Nurses Association | | | X | |
| Bev | Green | Group Health Research Institute | | X | | |
| Erin | Hafer | Community Health Plan of Washington | | | | X |
| Jeff | Harris | UW Health Promotion Research Center | | X | | |
| Jesus | Hernandez | Community Choice | | X | | |
| Kim | Herner | UW/Valley Medical Center Clinic Network | | | | X |
| Anne | Hirsch | Seattle University | X | | | |
| Jutta | Joesch | King County | | | | X |
| Kim | Kelley | WA State Critical Access Hospital Program | | | X | |
| Dan | Kent | Premera Blue Cross | | X | X | X |
| Larry | Kessler | University of Washington School of Public Health | X | | | |
| Mark | Koday | Yakima Valley Farmworkers Clinic | | X | | |
| Byron | Larson | Urban Indian Health Institute | X | | | |
| Dan | Lessler | WA State Health Care Authority | X | | | |
| Julie | Lindberg | Molina Health Care of Washington | | | | X |
| Kathy | Lofy | WA State Department of Health | X | | | |
| Julie | McDonald | Providence Regional Medical Center | X | | | |
| Sue | McDonald | Group Health Cooperative | X | | | |
| Paige | Nelson | The Everett Clinic | | | | X |
| Sheri | Nelson | Association of Washington Business | X | | | |
| Kim | Orchard | Franciscan Health System | | | | X |
| Janet | Piehl | UW Neighborhood Clinics | | X | | |
| Bayley | Raiz | Community Health Plan of Washington | | X | | |
| Scott | Ramsey | Hutchinson Center for Cancer Outcomes Research | X | | | |
| Charrisa | Raynor | SEIU Healthcare NW Training Partnership and Health Benefits Trust | X | | | |
| Marguerite | Ro | Seattle King County Public Health | X | | | |
| Terry | Rogers | Foundation for Healthcare Quality | | | X | |
| Rick | Rubin | OneHealthPort | X | | | |
| Larry | Schecter | WA State Hospital Association | | | | X |
| Torney | Smith | Spokane Regional Health District | X | | | |
| Jonathan | Sugarman | Qualis Health | X | | | |
| Julie | Sylvester | Qualis Health | | | | X |
| Dorothy | Teeter | WA State Health Care Authority | X | | | |
| Kyle | Unland | Spokane Regional Health District | | X | | |
| Carol | Wagner | WA State Hospital Association | X | | X | |
| Kristen | Wendorf | Seattle King County Public Health | | X | | |

## Invited/Did Not Respond to Survey on Prioritization of Topics for Future Measure Sets:

| Name | | Organization | Performance Measures Coordinating Committee | Prevention Workgroup | Acute Care Workgroup | Chronic Illness Workgroup |
|---|---|---|---|---|---|---|
| Jim | Freeburg | National Multiple Sclerosis Society, Greater NW Chapter | X | | | |
| Patrick | Jones* | Eastern Washington University Institute for Public Policy and Economic Analysis | | | X | |
| Michael | Myint | Swedish Health Services | | | X | |
| MaryKay | O'Neill | Regence Blue Shield | X | X | | |
| Dale | Reisner | Washington State Medical Association | X | | | |
| Maryilyn | Scott | Upper Skagit Indian Tribe | X | | | |

**Mr. Jones did offer written comment via email, but did not participate in the prioritization.*

## APPENDIX E: Verbatim Comments from Public Comment Period, Organized by Theme

## FEEDBACK ON SPECIFIC MEASURES CURRENTLY IN THE MEASURE SET

1. **ASTHMA**
   a. A recent Kaiser analysis did not find a correlation with the current measure and improved outcomes. Some concerns with the HEDIS Medication Management for People with Asthma (MMA) measure have recently been brought to the attention of NCQA based on this analysis. Specifically the potential flaws include: • It penalizes appropriate step-down of asthma controller therapy per the NIH guidelines• It penalizes the appropriate management of seasonal asthma• The relationship between the MMA measure and improved asthmas outcomes is unknown Recommendation: NCQA is now including the medication ratio measure described below, considered to be a better measure and more likely to influence better asthma management that also results in improved utilization of urgent and emergent care. The Asthma medication ratio (AMR): Description: The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

2. **AVOIDANCE OF ANTIOBIOTICS**
   a. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: As to the avoidance of antibiotics for acute bronchitis, we note that comments have been submitted to the PMCC by Kim Pittenger, MD concerning Virginia Mason's recent experience: "Our effort to improve performance via prescribing feedback and academic detailing was associated with a rapid coding shift. Codes for acute bronchitis fell and codes for cough rose. VM fell off the WSHA metric due to too few coded visits for acute bronchitis. We therefore developed a code cluster for URI of all kinds to reduce abx prescribing for all forms of URI substantially. Current WSHA acute bronchitis metric may not be capturing the event we are all trying to improve. "Based on Dr. Pittenger's comments, we would hope that use of a performance measurement for avoidance of antibiotics will accurately address the event that the state is working to improve.
   b. For pediatric strep, a rapid strep test followed by an antibiotic meets the measure, but no antibiotic prescribing rate measure means treating a negative strep result with antibiotics will be a 'positive', while using a validated decision rule and treating a high probability case without testing is a 'negative'.

3. **BLOOD PRESSURE CONTROL**
   a. I see reference for adjusting the BP target for those without diabetes to the new JNC8 recommendations. This should be codified at this time since those recommendations are just about 12 months old.

4. **CERVICAL CANCER SCREENING**
   a. We have some concern regarding the cervical screening measure. Specifically, this metric is challenging to measure for the younger age of the range, who are still seeing their general pediatricians as their primary care provider. As the measure requires sexual activity, this is very challenging to obtain from claims data in addition there may be limitations in self-reporting. We applaud the Alliance on the selection of a diverse group of measures which have incorporated the pediatric age population.

5. **COST**
   a. Medicaid Spending per Enrollee – Cost is an important metric and it is essential to make sure this measure is adjusted appropriately for meaningful differences in variation. We ask that this measure be adjusted.

6. **COPD**
   a. Spirometry Testing for COPD: We would recommend that for the outcomes that are most important for this population related to management of symptoms and decreasing cost, this is not the recommended measure. We agree and support the readmission for hospitalization measure as a much better focus for managing hospitalization and providing appropriate interventions to manage symptoms with medication management for COPD exacerbations.

7. **HIV SCREENING**
   a. Though we recognize that HIV is an important public health problem, and that universal screening for HIV is recommended by both the CDC and the USPSTF, we also have concerns about adopting a measure that has not yet been validated, tested or endorsed. This is slated to be a medical group performance measure. Given that the recommendation is for a single screening for average risk individuals, and that the appropriate interval for screening in higher risk individuals is not really known, this could prove to be a very difficult measure to assess. The 'look back period' could be quite long and attribution for performance to a group could be very misleading. We would recommend waiting until other groups, such as NQF have formally adopted and validated this measure for use as a medical group performance measure.

8. **IMMUNIZATION**
   a. Pneumococcal vaccine: There is not strong evidence that track well with outcomes associated with this measure. It is not a core HEDIS measure for some of these reasons. Would recommend reconsideration of this measure.

9. **MEDICATIONS/PRESCRIBING**
   a. Percent Generic Experience across the state and at Virginia Mason indicates that Washington already is at a high level of prescribing of generics; the state averages more than 87.6 percent. Moreover, the state already has several programs in place to promote the prescribing of generics. We question whether the inclusion of the proposed measure will enhance health care delivery.
   b. "Medication adherence: proportion of days covered" which seems impossible to measure accurately.

10. **MENTAL HEALTH**
    a. The 7-day Mental Health measure has long been controversial. There is a great need to clarify the data sought and revise the measure to ensure that data received is representative of the measure. Currently there is NO mechanism to capture engagement and outreach for non-enrolled consumer who discharge from a hospital. Allowing the engagement and outreach code to be recorded for this non-enrolled population would give a better picture of outreach and engagement attempts by the provider while continuing to allow consumers free choice about their follow up.
    b. Percentage of adults reporting 14 or more days of poor mental health is an arbitrary measure. It seems there ought to be a stronger question to gain the same information.
    c. Both the 7 day follow-up and 30 day readmission fall on the backs of mental health. The responsibility for this coordinated effort needs to be evenly balanced between mental health and the hospital/medical provider to ensure there is equal motivation to comply with this measure.

11. **ORAL HEALTH**
    a. Primary Caries Prevention: Group Health recognizes and agrees that oral health is an important component of health, and that the new evidence for prophylaxis with fluoride varnish in primary care is compelling. The UPSTF agreed with this in their most recent recommendation. As with HIV screening, there is currently no validated and endorsed measure in the national community. We believe that before a measure should be adopted, that these thresholds should be met. Group Health has fully integrated caries prevention as part of well care, and recognizes that there are some important challenges in measurement in this area. Though we believe that this represents a critical opportunity for innovation, we believe that the key stakeholders in this area should work to get a measure

developed, tested and validated before it is formally recognized by the state. The integration of medical and dental data is not trivial and there are no data repositories for the acquisition of dental data. Delta has offered to assist, which is outstanding, but there are many other dental plans which are not obligated to report data from their claims. This is an important area that needs further development.

**12. PATIENT SAFETY**

a. Complications/Patient Safety Composite – The National Quality Forum is currently reviewing and discussing changes to this measure. Given the potential for substantial changes, WSHA recommends the Committee consider postponing this measure from the starter set until changes are finalized. In the meantime, many of the measures within this composite measure are on the list as individual measures. The individual measures unlike the composite measure use commonly accepted definitions.

**13. THROMBOLYTIC THERAPY**

a. The thrombolytic therapy measure should include adverse outcomes from thrombolytic therapy (death/morbidity). Also needs to include contraindications to thrombolytic therapy.
b. tPA for stroke, this science is too controversial. Avoidable emergency visits cannot be defined properly. There is a subjective comment that it is a conservative measure, but this is not validated based on prudent layperson standard.

**14. USE OF EMERGENCY SERVICES**

a. Please substitute the following measure for #43 Avoidable ED Admissions. "Percent of Return ED visits w/I 72 hours with the same or similar diagnosis (Number of ED patients retuning either same or similar diagnosis to the ED within72hrs of their initial visit/Total ED Visits)X100"
b. (X3) Please substitute the following ED measure for #43 Avoidable ED Admissions. "Percentage of Return ED visits within 72 hours with the same or similar diagnosis. (Number of ED patients returning either same or similar diagnosis to the ED within 72 hours or their initial visit/Total ED visits) x 100". This is a measure that hospitals can do something about and it encourages community provider collaboration.
c. Not enough consideration for meeting standard of care around emergency care measures. There are many low back pain patients who require imaging based on history and physical exam findings and risk factors. Potentially avoidable services is too vague to measure and doesn't allow for the reason that a large majority of emergency patients access emergency care (4 out of 5 are sent by their physician). This retrospective data is not valid.
d. Psychiatric boarding times in emergency departments. Left without being seen rates (from emergency departments).

## GENERAL COMMENTS BY TOPIC AREA

1. **ADVANCED CARE PLANNING/END OF LIFE**
   a. Just to respectfully point out again that the SHCIP measures could be more effectively aligned with the Advance Care Planning, End of Life Care, and Conversation Project work being completed by the Honoring Choices PNW (WSHA/WSMA) Work Groups, Bree Collaborative and WAHA. Again, I asked that you consider elevating Measure #12 Continuity of Care: Advance Care Planning, currently listed in the Second Tier, to the First Tier Prioritization for the future measure set. Thank you for the opportunity to provide feedback and recommendations.
   b. Where is end of life planning?
   c. palliative/hospice/end-of-life care
   d. I had asked that there be a measure selected to measure the impact of efforts to increase the amount of consumers that have completed Advance Care Planning and the associated efforts to support and honor their choices at the end of life. I appreciate that they work group has placed this measure on the second tier list for future measures. I would like to propose that it be moved to the Top Tier prioritization.

2. **BEHAVIORAL HEALTH/ INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH**
   a. The measures do not adequately measure mental health or substance abuse disorders.
   b. In the context of MH Parity and the state's push towards service integration, I think it's important to address MH treatment penetration.
   c. We appreciate the inclusion of behavioral health and dental measures to reflect integration of physical, behavioral and oral health.
   d. The measures appropriately encompass mental and physical health centered outcomes.
   e. I want to encourage the work as it goes forward to better align with the relevant physical health and behavioral health measures selected by the 5732/1519 process,
   f. There is very little alignment with this set and the 1519/ 5732 measure set.
   g. There are credible screening tools for drug & alcohol, suicide, bipolar, anxiety and trauma (for a start, please see http://www.integration.samhsa.gov/clinical-practice/screening-tools). If we are truly going to integrate and provide holistic treatment we must start asking the appropriate questions.
   h. The 1519/ 5732 prioritized measures (that should be considered for inclusion) most likely to decrease cost and improve care are: ED visits, inpatient utilization, adult access to preventative care, MH treatment penetration, and alcohol/ drug treatment retention.

3. **COST**
   a. The measures must support quality patient care as well as cost of care.
   b. The measures must support quality patient care as well as cost of care.
   c. Measures that focus on cost reduction and oral health/overall health relationship are first priority.
   d. Seems short on prevention measures that could translate into reduced health care costs. Tobacco use is captured, but what about other drugs, including alcohol?

**4. ORAL HEALTH**

a. We appreciate the inclusion of behavioral health and dental measures to reflect integration of physical, behavioral and oral health.
b. We would like to express our support of the draft performance measures inclusion of an oral health preventive measure; Primary Caries Prevention Intervention as Part of Well Child Care as Offered by Primary Care Medical Providers. (WDS)
c. Measures that focus on cost reduction and oral health/overall health relationship are first priority.
d. We would like to an additional measure for oral health screenings for diabetics and pregnant women in primary care.
e. While I appreciate the inclusion of an oral health measure for children, I had hoped for an additional measure acknowledging the relationship of oral and overall health.

**5. PATIENT EXPERIENCE**

a. The core measures, even as "starters," fully and absolutely exclude ANY measure related to patient or community member satisfaction with delivered care, engagement and activation in acquiring care, engagement in the care process, education (preventive and management), or, perhaps most important, patient-provider collaboration. The core measures are the standard set of epidemiological and disease/condition intervention measures, as recommended by the AHRQ, but without any of the AHRQ's recommended measures for patient-perceived quality.
b. There should be more patient experience measures. Health is ultimately defined by people having access to the care and information they need to make the best decisions for themselves. Whether or not someone gets a flu shot or gets spirometry performed for their suspected COPD pales in importance to the experience of the patient in the provider's office or hospital. A dramatic transformation is taking place in health care in that decisions are no longer being made by doctors and other experts. The patient is now (thankfully) at the center. The experiences measures that were not adopted should be high priority for inclusion as soon as possible.

**6. STRATIFICATION/SOCIAL DETERMINANTS OF HEALTH**

a. I believe the measures selected and those prioritized for future consideration are valid; however, I would urge the committee to consider stratifying additional measures by race and ethnicity. There is significant evidence of racial disparities in disease prevalence and quality of care in Washington State, even while controlling for payer. All claims-based measures can be stratified by race, and BRFSS data can be stratified by race for counties for which there is sufficient sample size (King, Pierce, etc.). Stratification may uncover additional opportunities for quality improvement and the promotion of health equity in our state.
b. These are great measures and will go a long way to improving the health of our patients in Washington. I especially like the inclusion of patient experience data. I'd like to see more on social determinants of health though.
c. I think the measures that we would have to report on make sense. My only question is, with an emphasis on social determinants of health in the Healthier Washington plan, will there be measures that address any of these determinants?
d. I believe the measures selected and those prioritized for future consideration are valid; however, I would urge the committee to consider stratifying additional measures by race and ethnicity. There is significant evidence of racial disparities in disease prevalence and quality of care in Washington State, even while controlling for payer. All claims-based measures can be stratified by race, and BRFSS data can be stratified by race for counties for which there is sufficient sample size (King, Pierce, etc.). Stratification may uncover additional opportunities for quality improvement and the promotion of health equity in our state.
e. I'd like to see a few measures specifically looking at social determinants of health. I don't have enough expertise to say what to specifically measure but I know that social factors are paramount to the health of our patients.

**7. SUB-POPULATIONS**

a. Greater inclusion of measures that address health concerns for older adults (i.e.: fall prevention, etc.), and for work groups to address sub-populations (behavioral health, rural, older adults) where their unique needs are not understood or prioritized by those working with a more general population.
b. We would like to an additional measure for oral health screenings for diabetics and pregnant women in primary care.

**8. OBSTETRICS**

a. Obstetrics and related services are critical in ensuring healthy mothers and a healthy childbirth. We would like to have this more broadly recognized in the starter set. WSHA asks the Committee to consider adding the following measures: Breast Feeding (NQF 0480) – Hospitals are collecting this measure as part of Joint Commission certification for hospitals with over 1,100 births per year. WSHA supports the incorporation of this measure. Low Birth Weight Rate (PQI 9) (NQF 0278) – We believe this measure may have been missed in the final set since the discussion was split between the prevention and acute care workgroups. This measure is important in addressing health disparities and the health of a population and WSHA would ask that it be included.

**9. WHAT MEASURES ARE MISSING?**

a. Under the Population Health category, where the measure of adults smoking tobacco is presented, I wonder if smoking by youth should also be incorporated.
b. Additional consideration of chronic infectious diseases should be made for screening and viral suppression of HIV and Hepatitis.
c. Obstetrics Measures – Obstetrics and related services are critical in ensuring healthy mothers and a healthy childbirth. We would like to have this more broadly recognized in the starter set. WSHA asks the Committee to consider adding the following measures: Breast Feeding (NQF 0480) – Hospitals are collecting this measure as part of Joint Commission certification for hospitals with over 1,100 births per year. WSHA supports the incorporation of this measure. Low Birth Weight Rate (PQI 9) (NQF 0278) – We believe this measure may have been missed in the final set since the discussion was split between the prevention and acute care workgroups. This measure is important in addressing health disparities and the health of a population and WSHA would ask that it be included.
d. I do not recall seeing much about unintended pregnancy or disability. Both of these are outcomes sensitive to healthcare interventions and their undesirable outcomes have personal and economic consequences for the community that far exceed their healthcare-specific costs.
e. Early childhood development is entirely missing, yet abuse & neglect lead to both physical & mental health problems, not to mention social problems.
f. Under "Chronic Illness Measures," we proposed adding "Antithrombotic/Anticoagulation: % of patients with history of AF, valvular heart disease, TIA, ischemic stroke, and so forth who are prescribed proper antithrombotic/anticoagulation treatment." This is for the prevention and management of stroke, as well as related conditions such as Atrial Fibrillation. (Included links to research)
g. STEMI: Door-to-balloon times within 120 minutes
h. Hepatitis C screening
i. Gonorrhea screening

## GENERAL COMMENTS REGARDING PROCESS AND/OR OVERALL MEASURE SET

1. **COMMUNICATION AND OPPORTUNITY FOR INPUT**
   a. WSHA encourages discussion on how the results of this work will be presented to the public. It would be beneficial if the Authority convened a communications group to aid in the development of key messages. Some important measures have not been included in the set because Washington is already doing a great job. Other measures have been included when we all recognize we can and should do better.
   b. You do not have enough patient input.
   c. data gathering requirements are unclear, breadth of measures is expansive, expectations related to measures is undefined
   d. In reviewing the three PMCC Work Group rosters, we were unable to identify a single consumer or advocacy group. Businesses that will benefit were represented yet persons with lived experience - representing that unique viewpoint appear to purposely have been omitted. The PMCC did have NAMI, a nationally recognized family organization, thus making the MS Society the sole consumer voice, which was clear in listening to the audio of the meeting.
   e. Speak with and LISTEN to chronically ill patients - particularly senior citizens... who are left out on the street when Medicare refuses treatment for Lymphedema cellulitis wounds that show no signs of progress with home care nursing. They refuse to pay
   f. I heard about it just yesterday. Perhaps, the HCA may be able to communicate with large medical groups or specialty societies to solicit feedback, if not already doing it.
   g. I still have no idea how the selection was made. I would recommend leaving the selection process up to the medical experts.
   h. As I've addressed with Laura Pennington, it was difficult to understand the time frames and my inclusion was pretty late in the process which detracted from my ability to help ensure the measures selected by the PMCC were aligned with relevant 1519/5732 measures.
   i. Stakeholders were allowed to listen to the development work groups and make comments during the public comment period at the end of each session. I did participate at that level but sometimes wished I could comment along the way, not just at the end of the session.
   j. It wasn't terribly clear how to give input during the committee process and we are concerned the public comment period may be too late for additions to be made.
   k. Meetings should have been open for in person participation. The registration and call in process was complicated and burdensome. This was not an open public process that it could have been.
   l. For those of us in small rural communities not on the West side, there was little communication made available. Every hospital should have been communicated to about this work
   m. Needed Family Planning service providers/agencies on the planning group
   n. No opportunity was presented to me as a private practice MD
   o. Not aware of any invitations to participate

2. **DATA SHARING PRIOR TO REPORTING**
   a. Please ensure that processes for comment and examination of the data before publication or action are built into the process.

3. **ENGAGEMENT OF PROVIDERS**
   a. Finally, it is important that you reach out and get a lot of feedback from the medical community. It's not clear to me that your workgroup is comprised of many practicing physicians at all.
   b. More clinician input will help improve participation and save money.

**4. LACK OF CAPACITY FOR MEASUREMENT/BURDEN ON PROVIDERS**

a. Don't add or duplicate measures=make the definitions clear and concise=what or why are you wanting to measure something=know that information. Don't just ADD more work.
b. The measures need to take into consideration low patient volumes in small hospitals and respect the burden they experience retrieving the data.
c. These measures need to consider the low patient volumes in small hospitals and respect the burden of data mining they experience.
d. Please remember that what is needed is not just the indicators, but staff to ensure the quality of the data and to translate the data into information. Human resources may be more important than the indicators themselves. Again from Dr. Henderson: "A public health preoccupation today seems to be the creation of ever-more elaborate technologies that harvest hitherto unimaginable quantities of data. Never mind that the methodologies are ill conceived or the questions inappropriate. Too often sidelined are the professionals who would translate the findings into action." JHU Public Health 2012: Technology Special Issue (p.11).
e. 53 measures is too burdensome.
f. This is a comprehensive set of measures, possibly too comprehensive? Is it really sustainable to track this many indicators or would it be more efficient and manageable to narrow it down? Here are potentially applicable thoughts from someone whose track record speaks for itself: "A word of caution, however, should be said about goals. We endeavored to keep the number to not more than five operational ones. Obviously, there were hundreds of possible measurements of progress that could have been requested and compiled. Our experience, however, was that when the number got beyond four or five, key staff became so involved in submitting and compiling data that few used the data for the purpose for which it was intended—in monitoring the strengths and weaknesses in program implementation."
g. Is the measure set coordinated with other existing measure sets, or is this going to be an additional administrative burden placed upon physician offices that will requires more administrative time and further drive up the cost of healthcare?
h. I understand that keeping track of the health of our community is very important, but there are a lot of measures. For small Rural Health Clinic and CAH, especially ours, the resources to constantly and consistently extract information and submit is very time consuming and expensive. We pretty much run a skeleton crew to help keep costs down but with more and more measures, I am afraid this will overwhelm our current situation.
i. Incomplete data or a high level burden to collect data is associated with some measures. I am concerned that hospitals and providers will experience punitive financial actions (payment and public relations) related to data that is incomplete. There must be an avenue for examination of the data and publication of explanation of results.
j. There are already too many for small practices.

**5. LOW VOLUME/SMALL PROVIDER ORGANIZATIONS**

a. WSHA is concerned with measures where there may be low volume and could potentially be misleading in reports. While issues of low volume may be present in many small provider groups, it is especially relevant to rural providers and hospitals. We are pleased that the Committee and the Authority have agreed to further discussions on how measures with low volume will be used.
b. Measures need to support all care settings including small critical access hospitals. We need to be aware of data collection burden in small hospitals with limited means. We suggest pilot studies prior to implementation.
c. We concur with the comments of the Washington State Hospital Association (WSHA) that once the starter set of measures is finalized, the state should be cautious as to the use of measures "where there may be low volume and could potentially be misleading in reports." We are gratified that PMCC and the Health Care Authority have agreed to further discussions on how measures with low volume will be used.
d. Some measures do not have a high confidence in the ability to measure the data. Small hospitals may not have enough cases to be represented in the reporting.

**6. SIZE OF MEASURE SET**

a. This is a comprehensive set of measures, possibly too comprehensive? Is it really sustainable to track this many indicators or would it be more efficient and manageable to narrow it down? Here are potentially applicable thoughts from someone whose track record speaks for itself: "A word of caution, however, should be said about goals. We endeavored to keep the number to not more than five operational ones. Obviously, there were hundreds of possible measurements of progress that could have been requested and compiled. Our experience, however, was that when the number got beyond four or five, key staff became so involved in submitting and compiling data that few used the data for the purpose for which it was intended—in monitoring the strengths and weaknesses in program implementation."
b. This is an excellent start utilizing measures that are available, reliable with the majority of measures used by other quality reporting bodies (e.g., Health Alliance, NCQA, Medicare 5 Star). We recommend considering the size of the measure set, especially given it is a starter set. This is a significant list, not all of which are currently utilized or captured by Health Plans or provider groups. There are some measures, even if they are utilized by other bodies (State of Minnesota would be an example for oral health) but may not yet have been widely adopted to be certain of their efficacy or are not as strongly supported by clinical evidence and/or not yet fully tested (e.g., the HIV screening measure). We would ask that the committee consider opportunities to decrease the size of the measure set, particularly with measures that do not have solid experience and use.
c. This is a significant list, not all of which are currently utilized or captured by Health Plans or provider groups. There are some measures, even if they are utilized by other bodies (State of Minnesota would be an example for oral health) but may not yet have been widely adopted to be certain of their efficacy or are not as strongly supported by clinical evidence and/or not yet fully tested (e.g., the HIV screening measure). We would ask that the committee consider opportunities to decrease the size of the measure set, particularly with measures that do not have solid experience and use.
d. I understand that keeping track of the health of our community is very important, but there are a lot of measures. For small Rural Health Clinic and CAH, especially ours, the resources to constantly and consistently extract information and submit is very time consuming and expensive. We pretty much run a skeleton crew to help keep costs down but with more and more measures, I am afraid this will overwhelm our current situation.
e. There are already too many for small practices.

**7. EVOLUTION OF MEASURE SET**

a. We are pleased the legislation recognizes that this is ongoing work. The measure set needs to evolve to address changing priorities and to reflect changes in evidence-based care. (WSHA)
b. It will be important to remain flexible in adjusting the measures chosen or in eliminating unusual measures. In particular measures like specific BP targets or A1c targets or specific medications for medical conditions could become problematic as more information's comes available about clinical practice. Even a decade ago we had different evidence regarding things like BP targets or A1c targets or the need for certain medication post MI.
c. We commend PMCC's identification and proposed use of existing measures rather than attempting to create new measures. In the future, as the state's health care priorities evolve and changes occur in evidence-based care, applicable measures also should evolve for use in the state.
d. The key is to posit several measures that span a couple of care settings, and means of tabulation and get those underway as a means of introducing accountability. That concept is as important as the actual measures.

## APPENDIX F: SUMMARY OF WORKGROUP DELIBERATIONS AND ACTIONS IN RESPONSE TO COMMENTS/SUGGESTIONS MADE DURING PUBLIC COMMENT PERIOD

**PREVENTION MEASURES WORKGROUP:**

| **Measure to Reconsider** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **ORAL HEALTH: PRIMARY CARIES PREVENTION** | Recognition that oral health is an important component of health and that the new evidence for prophylaxis with fluoride varnish in primary care is compelling. The UPSTF agreed with this in their most recent recommendation. But currently no validated and endorsed measure in the national community. The integration of medical and dental data is not trivial and there are no data repositories for the acquisition of dental data. This is an important area that needs further development. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | The recommended measure is NQF-endorsed (#1419). It is also endorsed by the Association of State and Territorial Dental Directors. However, it is not a widely used measure. This will be a new area of measurement in WA, so in the first year there will certainly be significant implementation issues; this metric will require a lot of work by health plans. The workgroup recommends that this only be measured at a state and health plan level initially. The workgroup agrees this is an important area of health care and that we need to increase focus on it; measurement and reporting can help move the community forward. We will need to be careful in assessing the baseline, setting targets and using results as the early data is likely to be quite incomplete. |
| **CERVICAL CANCER SCREENING** | Concern that the measure is challenging to measure for the younger age of the range, (potentially still seeing their general pediatricians as their primary care provider). As the measure requires sexual activity, this is very challenging to obtain from claims data in addition there may be limitations in self-reporting. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | The comment appears to raise concerns about a different measure; cervical cancer screening does not require identification of sexual activity. This measure is a nationally endorsed and widely-used measure. As NCQA requirements change in response to technology changes, our measure specifications will change as well. |
| **HIV SCREENING** | Recognition that HIV is an important public health problem, and that universal screening for HIV is recommended by both the CDC and the USPSTF, but concerns about adopting a measure that has not yet been validated, tested or endorsed. This is slated to be a medical group performance measure. Given that the recommendation is for a single screening for average risk individuals, and that the appropriate interval for screening in higher risk individuals is not really known, this could prove to be a difficult measure to assess. The 'look back period' could be quite long and attribution for performance to a group could be very misleading. Recommend waiting until other groups, such as NQF have formally adopted and validated this measure for use as a medical group performance measure. | **RECOMMENDATION: <u>REMOVE</u> THIS MEASURE FROM THE STARTER SET.**<br><br>**PLACE HIV-RELATED MEASURES ON THE HIGH PRIORITY DEVELOPMENT LIST FOR FUTURE CONSIDERATION** | Upon further consideration, the workgroup has confirmed that, while routine HIV screening is strongly recommended by both the USPSTF and the CDC, there is no vetted and approved measure (with accompanying definitions and detailed measure specifications) in place at this time.<br>Therefore, the **workgroup recommends removing HIV screening from the starter set**. |

| **Measure to Reconsider** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **PNEUMOCCOCAL VACCINE** | There is not strong evidence that tracks well with outcomes associated with this measure. It is not a core HEDIS measure for some of these reasons. Would recommend reconsideration of this measure. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | According to NQF documentation that we reviewed, there is substantial evidence supporting the efficacy of the vaccine. The fact that NCQA does not consider the measure for health plan accreditation purposes does not mean that there is no evidence supporting the vaccine's effectiveness.<br>The workgroup is aware that national guidelines have changed and this measure will be updated going forward. We will continue to monitor the national measure specifications and update the adopted measure appropriately.<br>The workgroup has recommended using the WA IIS registry data, so it will be important to footnote that the results will not be comparable to the HEDIS measure (which is based on member survey response data). |

**Other Topics:**

| **Topic** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **ADDITIONAL ORAL HEALTH MEASURES** | Would like to see additional measures for oral health screenings for diabetics and pregnant women in primary care. | **MAINTAIN RECOMMENDATION; DO NOT ADD ADDITIONAL MEASURES TO THE CORE MEASURE SET** | Oral health is a significant area of interest; the workgroup has already recommended one oral health measure for inclusion in the core set. The workgroup recommends that the state prioritize additional oral health measures for inclusion in future versions of the measure set The "next best measure" is not clear at this time. Given the challenges with implementing the measure currently selected, the workgroup suggests that we concentrate early efforts on getting this one in place before adding measures. |
| **STRATIFICA-TION/SOCIAL DETERMINANT OF HEALTH** | Would like see more on social determinants of health; with an emphasis on social determinants of health in the Healthier Washington plan, will there be measures that address any of these determinants?<br>Urge the committee to consider stratifying additional measures by race and ethnicity. There is significant evidence of racial disparities in disease prevalence and quality of care in Washington State, even while controlling for payer. All claims-based measures can be stratified by race, and BRFSS data can be stratified by race for counties for which there is sufficient sample size (King, Pierce, etc.). Stratification may uncover additional opportunities for quality improvement and the | **MAINTAIN RECOMMENDATIONS; DO NOT ADD ADDITIONAL MEASURES TO THE CORE MEASURE SET.** | Re: Social determinants: Workgroup had a lengthy discussion re: the nature of social determinants of health and their impact on health, as well as the need for focused strategies, particularly through Accountable Communities of Health, public health and other community-based initiatives. While this area is recognized as a priority, there was agreement that it is very difficult to impact these issues within a clinical setting. The workgroup would like to see the state continue to explore how measures of social determinants of health can be effectively linked to performance improvement opportunities within the health care delivery system.<br>The workgroup has already recommended that measures be stratified by race and ethnicity when it is possible to do so. Currently this can be done using Medicaid claims data, but stratification is not possible using commercial claims data at this time. |

| | promotion of health equity in our state. | | |
|---|---|---|---|
| **Topic** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
| **YOUTH TOBACCO USE** | Under the Population Health category, where the measure of adults smoking tobacco is presented, I wonder if smoking by youth should also be incorporated. | **DO NOT ADD ADDITIONAL MEASURES TO THE CORE MEASURE SET** | The workgroup considered a measure based on the Healthy Youth Survey that Washington administers every other year. Not all school districts implement the survey. Since the information is collected via schools, it is impossible to map results to practices and health plans, and there are few youth tobacco cessation resources available in communities (these tend to be socially oriented). The workgroup identifies this situation as a significant deficiency that hinders measurement and management of youth programs for smoking cessation. |
| **OBSTETRICS** | Obstetrics and related services are critical in ensuring healthy mothers and a healthy childbirth and would like to see this more broadly recognized in the starter set. WSHA asks the Committee to consider adding two measures: Breast Feeding (NQF 0480) – Hospitals are collecting this measure as part of Joint Commission certification for hospitals with over 1,100 births per year. Low Birth Weight Rate (PQI 9) (NQF 0278) – We believe this measure may have been missed in the final set since the discussion was split between two workgroups. | **RECOMMENDATION:**<br><br>**<u>ADD</u>: EXCLUSIVE BREAST FEEDING (NQF 0480)**<br><br>**DO <u>NOT</u> ADD LOW BIRTH WEIGHT MEASURE (NQF 0278)** | Breast Feeding (NQF 0480): When the measure was initially considered by the workgroup, there was concern about the ability to collect this data. Other concerns included: (1) the measure does not include births outside the hospital setting; (2) not all hospitals are currently collecting this data, and (3) the measure is quite limited in that it only measures breast feeding during the newborn's hospitalization. Upon re-consideration, the workgroup concluded that (1) strong evidence in support of breast feeding (USPSTF recommendation), (2) the breastfeeding measure is a Joint Commission measure, (3) hospitals (with TJC accreditation) are already collecting this data and (4) WSHA has committed to help collect results from this measurement. Workgroup recommends adding this measure to the starter set.<br>Low Birth Weight Rate (PQI 9) (NQF 0278): Results for this measure would only be available at the state level and it did not rise to the level of priority of the other measures. Additionally, it is difficult to determine how to impact this issue in the clinical setting (beyond the smoking cessation issue that is already on the list). |
| **EARLY CHILDHOOD DEVELOP-MENT SCREENING** | Early childhood development is entirely missing, yet abuse & neglect lead to both physical & mental health problems, not to mention social problems. | **DO NOT ADD ADDITIONAL MEASURES TO THE CORE MEASURE SET** | The workgroup previously considered the Developmental Screening measure (NQF 1448). The workgroup noted that the USPSTF released a draft recommendation on November 18, 2014 noting there is insufficient evidence to recommend screening for speech and language delays. Clinicians also noted that basic standards for early childhood care already include regular review of how children are meeting developmental milestones. More specific assessment of speech and language delay typically is initiated if a child is identified as falling behind developmental milestones. |

| Topic | Summary of Public Comment | ACTION BY WORKGROUP | Summary of Workgroup Discussion |
|---|---|---|---|
| **HEPATITIS C SCREENING** | Add a Hepatitis C screening measure | **DO NOT ADD ADDITIONAL MEASURES TO THE CORE MEASURE SET** | While the general screening recommendation has been made, measurement specifications have not been set up. Measures of screening compliance will require significant look back periods in the data. Also, treatment protocols for positive hepatitis C – who to treat and when -- are not well-established; it is unclear who needs near-term treatment due to high risk of progressive liver disease. Widespread screening could potentially create a very large cohort of individuals demanding treatment when good clinical studies on who needs treatment are not yet complete. |
| **GONORRHEA SCREENING** | Add a Gonorrhea screening measure | **DO NOT ADD ADDITIONAL MEASURES TO THE CORE MEASURE SET** | Generally speaking, when physicians order chlamydia screening tests, the patient also receives screening for gonorrhea. Therefore the chlamydia measure (which is on the list) is a good proxy for gonorrhea screening as well. |

**ACUTE CARE MEASURES WORKGROUP:**

| Measure to Reconsider | Summary of Public Comment | ACTION BY WORKGROUP | Summary of Workgroup Discussion |
|---|---|---|---|
| **FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS @ 7 DAYS, 30 DAYS (Measure #17)** | Long been a controversial measure; no mechanism to capture engagement and outreach for non-enrolled consumer | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | Workgroup recognizes that measure is not perfect, but it is an NCQA-HEDIS measure in wide use and is NQF-endorsed. Acknowledge the desire to improve the depth and accuracy of measurement in this important area, but also recognize that systems do not exist today to support capture of follow-up data for uninsured or non-enrolled consumers by provider organizations or health plans. |
| **AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS (Measure #29)** | Evidence of coding behavior change to improve results on measure (coding for bronchitis dropped; coding for cough increased). Suggest using code cluster for URI. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | The workgroup discussed multiple topics: (1) shifting of coding away from "bronchitis" to improve performance has been reported; this type of shift is a risk for many measures and suggests a larger problem related to lack of a QI culture; (2) a URI code cluster is being used locally but is not vetted on a larger scale (not NQF or NCQA endorsed); (3) maintaining this measure on the list is important given known overuse of antibiotics and the significant public health issue that this raises. |

| Measure to Reconsider | Summary of Public Comment | ACTION BY WORKGROUP | Summary of Workgroup Discussion |
|---|---|---|---|
| **APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS (Measure #22)** | Measure penalizes clinicians who utilize a validated decision rule (based on clinical history and findings rather than a rapid strep test) and who treat a high probability case. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | Committee clinicians don't see much use of such clinical rules, so this omission is not expected to affect the usefulness of the measure as an indicator of overuse of antibiotics. |
| **POTENTIALLY AVOIDABLE ED VISITS (Measure #43)** | Suggests replacing this measure with the following: # of ED patients returning to the ED with same or similar diagnosis within 72 hours of their initial visit X 100 This is a measure that hospitals can do something about and encourages community provider collaboration.<br><br>Potentially avoidable services are too vague to measure and don't allow for the reason that a large number of patients are sent to the ED (sent by their physician). | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | Suggestion made by Rural Health Quality Network, indicating this is a measure they have been focused on. Workgroup noted that suggested measure reflects a combination of illness and access. It is not a substitute for the Avoidable ED Visit measure as it really measures something different. Workgroup noted that the suggested measure is similar to (but not the same as) Measure # 44 already on the list: Patients w/ 5 or More ED Visits without Care Guideline. Data source for the suggested measure over the longer term was reported to be unreliable as the RHQN is voluntary and in transition. Workgroup suggests considering suggested measure in the future.<br>The potentially avoidable ED visit measure has limitations in that it is not certain that the visits are avoidable; also true that many patients told to go to ED by their physician. Nonetheless, this measure provides a meaningful indicator of potentially unneeded and costly use of ED services. |
| **STROKE: THROMBOLYTIC THERAPY (Measure #48)** | Measure should include adverse outcomes from thrombolytic therapy (morbidity/death); also needs to include contraindications. Science related to this therapy is still too controversial. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | Workgroup notes that the contraindications are already taken into account in the measure denominator; this is a Joint Commission measure and science is well established. Detailed clinical data related to adverse outcomes not readily available to support statewide reporting. |
| **COMPLICATIONS/PATIENT SAFETY COMPOSITE (Measure #50)** | NQF is currently reviewing and discussing potential changes to this AHRQ-sponsored measure. WSHA recommends postponing the measure until changes finalized. WSHA notes many of the 11 measures within this composite are on the list as individual measures. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | NQF regularly reviews proposals to modify measures; this is not the only measure in the measure set for which changes are being considered. While it is important to have an active process for monitoring changes to measures by NQF, NCQA and other national bodies, the work group did not think that measures should be removed just because the certifying body is considering changes. Also, measures of the individual components are not included elsewhere in the recommended measure set and this is the only measure related specifically to patient safety and adverse events related to inpatient care." The composite was selected, in part, because rates on individual components can be very low, resulting in harder to understand results and unreportable data for many organizations (small N). |

Other Topics:

| **Topic** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **PSYCHIATRIC BOARDING IN ERS** | Psychiatric boarding times in emergency departments. Left without being seen rates (from emergency departments). | **NO FURTHER ACTION** | Very important issue. It was noted that most (all?) hospitals are actively working on this issue and there is a statewide effort to address the shortage of appropriate beds. Workgroup thought that the topic did not have accurate, vetted measurement sources available for public reporting at this time. |
| **STRATIFY MEASURES BY RACE/ETHNICITY** | Urge the committee to consider stratifying additional measures by race and ethnicity. There is significant evidence of racial disparities in disease prevalence and quality of care in Washington State, even while controlling for payer. All claims-based measures can be stratified by race, and BRFSS data can be stratified by race for counties for which there is sufficient sample size (King, Pierce, etc.). Stratification may uncover additional opportunities for quality improvement and the promotion of health equity in our state. | **NO FURTHER ACTION** | Measure stratification by race/ethnicity. Workgroup agreed that stratification of measure results is important and that we should do so as the data permits. Three of the acute care measures currently are recommended for stratification (Medicaid only). Group acknowledged that, currently, only Medicaid data permits this type of stratification using readily available data. County level reporting recommended for five measures which will add further information regarding rural/urban differences. |

**CHRONIC ILLNESS MEASURES WORKGROUP:**

| **Measure to Reconsider** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **BLOOD PRESSURE CONTROL** | I see reference for adjusting the BP target for those without diabetes to the new JNC8 recommendations. This should be codified at this time since those recommendations are just about 12 months old. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | The comment on p.21 of the recommendations document distributed to the Coordinating Committee is incorrect (apologies!!); NCQA has already made changes to the HEDIS blood pressure control measure to reflect the JNC guideline changes, and the workgroup has recommended use of the NCQA measure (NQF #0018).<br>*Note: The narrative in the final recommendations will be adjusted to reflect that the recommended measure is the HEDIS measure which already reflects the updated clinical guidelines.* |

| **Measure to Reconsider** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **ASTHMA: USE OF APPROPRIATE MEDICATION** | A recent Kaiser analysis did not find a correlation with the current measure and improved outcomes. Some concerns with the HEDIS **Medication Management for People with Asthma (MMA)** measure have recently been brought to the attention of NCQA based on this analysis. Specifically the potential flaws include: • It penalizes appropriate step-down of asthma controller therapy per the NIH guidelines• It penalizes the appropriate management of seasonal asthma• The relationship between the MMA measure and improved asthma outcomes is unknown. Recommendation: NCQA is now including the medication ratio measure, considered to be a better measure and more likely to influence better asthma management that also results in improved utilization of urgent and emergent care. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | The recommended measure is <u>not</u> the HEDIS MMA measure. The recommended measure is titled Use of Appropriate Medications for People with Asthma (ASM) which is a NCQA claims-based measure (NQF #0036).<br><br>The Asthma Medication Ratio (AMR) measure was placed on the high priority development list. The workgroup supports the use of this measure in the future but the measure requires both claims and clinical data. As the clinical data is not available at this point in time, the workgroup placed this measure on the list for future consideration. |
| **COPD: USE OF SPIROMETRY TESTING** | We would recommend that for the outcomes that are most important for this population related to management of symptoms and decreasing cost, this is not the recommended measure. We agree and support the readmission for hospitalization measure as a much better focus for managing hospitalization and providing appropriate interventions to manage symptoms with medication management for COPD exacerbations. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | This measure focuses on use of spirometry to aid diagnosis (rather than ongoing management). Clinician members of the workgroup make the case that accurate diagnosis is important as it is not uncommon for people to be placed on long term, expensive medication for COPD when they do not have COPD.<br>In the commercial and Medicaid populations, we expect that there will be too few COPD readmissions to collect meaningful/ publicly reportable data.<br>Also, the workgroup noted that they have recommended the AHRQ PQI measure to assess ambulatory care sensitive hospital admissions for COPD. |
| **MEDICATION ADHERENCE: PROPORTION OF DAYS COVERED** | This measure seems impossible to measure accurately. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | While it is true that it is impossible to measure whether a patient is actually taking their medication, this measure assesses whether the patient gets enough medication refills to adhere to the medication as prescribed. WA is not currently using this measure but the Pharmacy Quality Alliance has agreed to provide the WA Health Alliance with the detailed specifications. There may be some challenges with the implementation but the workgroup felt that the measure was important enough to recommend the measure. Inclusion of this measure on the starter is supported by pharmaceutical representatives and the WA State Pharmacy Association. |

| **Measure to Reconsider** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **GENERIC PRESCRIBING** | Experience across the state and at Virginia Mason indicates that Washington already is at a high level of prescribing of generics; the state averages more than 87.6 percent. Moreover, the state already has several programs in place to promote the prescribing of generics. We question whether the inclusion of the proposed measure will enhance health care delivery. | **MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET** | This topic was thoroughly discussed multiple times within the Chronic Illness Measures Work Group and there was agreement that existing variation in practice indicates ongoing opportunity for improvement in generic medication prescribing. With room for continued improvement, the potential cost savings for even a 1-2% improvement are substantial. |

**Other Topics:**

| **Topic** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **PATIENT EXPERIENCE** | The core measures, even as "starters," fully and absolutely exclude ANY measure related to patient or community member satisfaction with delivered care, engagement and activation in acquiring care, engagement in the care process, education (preventive and management), or, perhaps most important, patient-provider collaboration.<br>There should be more patient experience measures. | **MAINTAIN RECOMMENDATION; DO NOT ADD ADDITIONAL PATIENT EXPERIENCE MEASURE** | The workgroups have included three patient experience measures (two hospital, one ambulatory) in the recommended starter set: (1) Communication about Medications (hospital), (2) Discharge Instructions (hospital) and (3) Provider Communication (primary care). With limitations on the number of measures to be included in the starter set, the workgroups felt that these were the most important patient experience measures to include. |

| **Topic** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
|---|---|---|---|
| **ADVANCED CARE PLANNING/END OF LIFE** | The measures could be more effectively aligned with the Advance Care Planning, End of Life Care, and Conversation Project work being completed by the Honoring Choices PNW (WSHA/WSMA) Work Groups, Bree Collaborative and WAHA. Ask that you consider elevating Advance Care Planning, currently listed in the Second Tier, to the First Tier Prioritization for the future measure set.<br>Where is end of life planning? | **KEEP ADVANCED CARE PLANNING/END OF LIFE ON THE HIGH PRIORITY DEVELOPMENT LIST FOR CONSIDERATION IN FUTURE YEARS** | The workgroup agreed that this is a very important area of work and it is on the high priority development list for further consideration. More effective use of advanced care planning and end of life conversations can improve quality of life and reduce cost. However, the workgroup expressed concern about this area for measurement and public reporting, noting that "not everything that counts can be counted." This is a complex area insofar as reasons for involvement of health plans, practitioners and provider organizations in end-of-life matters can be easily misinterpreted. |
| **COST MEASURES** | Medicaid spending per Enrollee: Cost is an important metric and it is essential to make sure this measure is adjusted appropriately for meaningful differences in the population. | **MAINTAIN RECOMMENDATION; NO FURTHER ACTION** | The workgroup agrees that the cost measures need additional definition development. This has already been noted in the recommendations. |
| **LOW VOLUME, RURAL AND CRITICAL ACCESS PROVIDERS** | A workgroup member wanted to know what work will be done with regard to the measurement of low volume providers and providers in rural areas and Critical Access Hospitals. | **NO FURTHER ACTION** | WHSA has volunteered to lead a workgroup to discuss metrics that are applicable, fair and feasible for critical access hospitals and rural hospitals to implement. So a process has already been identified to further this work for CAHs and rural hospitals.<br><br>Additionally there needs to be further discussion by the state about how it will handle performance measurement and public reporting when there is a preponderance of results with a small N. |

| **Topic** | Summary of Public Comment | **ACTION BY WORKGROUP** | Summary of Workgroup Discussion |
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| **BEHAVIORAL HEALTH/INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH** | Mix of comments:<br><br>The measures do not adequately measure mental health or substance abuse disorders.<br><br>There is very little alignment with this set and the 1519/ 5732 measure set. The 1519/ 5732 prioritized measures (that should be considered for inclusion) most likely to decrease cost and improve care are: ED visits, inpatient utilization, adult access to preventative care, MH treatment penetration, and alcohol/ drug treatment retention.<br><br>The measures appropriately encompass mental and physical health centered outcomes. | **MAINTAIN RECOMMENDATIONS AS IS; DO NOT RECOMMEND ADDITIONAL MEASURES AT THIS TIME**<br><br>**RECOMMEND MOVING THE SUBSTANCE ABUSE MEASURES TO THE TOP TIER OF HIGH PRIORITY DEVELOPMENT TOPICS** | The state has created a crosswalk that shows where there is alignment between the recommended starter set measures and the 1519/5732 measures. The workgroup briefly re-reviewed the measures included in the 1519/5732 work and noted again where there is alignment, particularly in areas that focus on health care delivery. It was noted that some of the 1519/ 5732 measures are thought to be beyond the scope of this work:<br>• Quality of life<br>• Criminal justice and forensics<br>• Housing, employment, education and meaningful activities<br>It was also noted that finalized measures are not yet completed in all areas.<br><br>During the workgroup process, the workgroup was very interested in adding a SBIRT or substance abuse service penetration measure but struggled to find a measure that would be feasible to implement at this time.<br><br>The workgroup would like the report to reflect that they are particularly interested in future inclusion of measures related to screening/ intervention and mental health and substance abuse service penetration when it is feasible to do so. |